PLUMBERS' UNION, LOCAL NO. 12
WELFARE FUND
SUMMARY PLAN DESCRIPTION

EFFECTIVE
September 1, 2021

D*ear Participants:*

We are pleased to provide you with this updated Summary Plan Description, dated [date], which will describe the benefits that are available to you and your eligible Dependents. This booklet describes:

1. *The current rules of eligibility. These rules are used to determine when you are eligible for coverage under the Plan and the procedures to be followed:*

   - *prior to seeking treatment;*
   - *when filing a claim for benefits; or*
   - *when appealing a denial of benefits.*

2. *The current benefits available through the various insurance carriers,* ***in outline form only****. Please refer to your description of benefit booklets from the Insurer(s) providing your coverage for a more detailed description of your benefits.*

This booklet, together with any applicable insurance certificates, provides a description of the benefits to which Participants and eligible Dependents are entitled, the rules governing these benefits, and the procedures that must be followed when making a claim or appealing a claim denial. Also, included in the back of this booklet is certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THIS PLAN WHENEVER, IN THEIR JUDGMENT, CONDITIONS SO WARRANT. THE TRUSTEES HAVE COMPLETE DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY FOR BENEFITS UNDER THE PLAN OR TO CONSTRUE AND INTERPRET THE TERMS OF THE PLAN, INCLUDING AMBIGUOUS OR DISPUTED TERMS AND MEANINGS, AND ANY OTHER INSTRUMENTS OR POLICIES OF THE FUND.

THE TRUSTEES HAVE DISCRETIONARY AUTHORITY TO MAKE ALL FACTUAL FINDINGS.

This booklet replaces all other Summary Plan Descriptions previously published by the Trustees. Be sure that you and your Dependents read this Summary Plan Description so that you and your family are familiar with your benefits. If you have any questions on claims payment, benefit coverage, or eligibility rules please do not hesitate to call the Fund Office at (617) 288-5400 or toll free 1-800-452-9995.

Sincerely,

Board of Trustees

GENERAL INFORMATION

PLAN OFFICE	PLUMBERS' UNION. LOCAL NO. 12 WELFARE PLAN 1230-1236 Massachusetts Avenue Boston, MA 02125 Telephone No.: (617) 288-5400 Fax No.: (617) 288-3871
EMPLOYER TAX I.D. NUMBER	04-2157164
PLAN NUMBER	501
PLAN YEAR	September 1 through August 31
TYPE OF PLAN	This is an insured Employee Welfare Benefit Plan consisting of Medical Benefits, Dental Benefits and Life Insurance for Participants, Retirees and their eligible Dependents. The Trustees offer benefits to Retirees who are not eligible for Medicare on a subsidized self-pay basis. The Trustees also offer retirees coverage that supplements Medicare benefits. All benefit plans are part of the same Employee Health Benefit Plan offered by the Board of Trustees (the Plan Administrator). Insurance premiums are paid from the Fund's assets and any investment earnings, which are held in trust for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses.
PLAN ADMINISTRATOR	Board of Trustees of the Plumbers' Union, Local No. 12 Welfare Fund 1230-1236 Massachusetts Ave. Boston, MA 02125 Telephone No.: (617) 288-5400

This Fund is a group health plan administered by a Board of Trustees, consisting of four Labor representatives and four Employer representatives. The names of the Trustees are available from the Fund Office.

a. The Trustees are authorized to amend, modify or discontinue all or any part of the Fund.
b. In the event of a plan amendment, you will be notified of the amendment within a reasonable period of time.
c. In the event of Fund termination, the assets of the Fund shall be applied to pay obligations of the Fund. Any surplus shall be distributed by the Trustees in a manner consistent with the purpose of the Fund. No part of the assets of the Fund shall revert to a Contributing Employer or the Union.

AGENT FOR SERVICE OF

PLAN ADMINISTRATOR. Legal process LEGAL PROCESS may also be made upon a Trustee.

PLAN FUNDING

Contributions to the Fund are made by Contributing Employers in accordance with collective bargaining agreements with the Plumbers' Union, Local No. 12 or other written agreement with the Board of Trustees. Participants and/or their Eligible Dependents may contribute in amounts required under the Plan.

Copies of collective bargaining agreements may be obtained by Participants, Eligible Dependents and beneficiaries at a reasonable cost upon written request to the Fund Administrator and are available for examination at the Fund Office during regular business hours. The Fund Office, upon written request, will also provide you with information as to whether or not a particular Employer or employee

organization is a sponsor of the Fund and if the Employer or employee organization is a sponsor, the sponsor's address. Such information may also be examined by Participants, Eligible Dependents and beneficiaries at the Fund Office during normal business hours.

The Fund's assets and reserves are invested by the Board of Trustees or by investment managers or advisors selected by the Board of Trustees.

PLAN OF BENEFITS

Circumstances that may result in disqualification, ineligibility for, or denial, loss, forfeiture or suspension of any benefits are fully described in this booklet.

All current benefits provided are set forth in the booklets provided by the Insurers.

The procedures to follow for filing a claim for benefits are set forth in Section 15 of this booklet. If all or any part of your claim is denied, you may request a review of that decision in accordance with the procedures in Section 15 H (1) of this booklet.

Insurance Companies:
To find a provider, see the network directory provided by the Insurer.

Blue Cross Blue Shield of Massachusetts (BCBSMA): Medical, Surgical, Hospitalization, Pharmacy, Routine Eye Care, Mental Health & Substance Use Disorders
P.O. Box 986030
Boston, MA 02298
Member Services Line: **1-800-241-0803**
Web: https://planinfo.bluecrossma.com/customblue/2019/plumberslocal12welfarehmoplan
Hours: Monday through Friday 8 A.M. to 6 P.M.

Pharmacy Benefit Manager through Blue Cross Blue Shield of Massachusetts
Express-Scripts
800-892-5119
www.express-scripts.com

Blue Cross Blue Shield of Massachusetts (BCBSMA)
Mental Health and Substance Abuse benefit
1-800-444-2426: Available 24 Hours, 7 days per week
www.bcbsma.com

Modern Assistance Programs, Inc. …Employee Assistance Program
1400 Hancock Street
Quincy, MA 02169
617-774-0331

Altus Dental Company……Dental Care
10 Charles Street
Providence, RI 02904
877-223-0588
www.altusdental.com

Davis Vision…. Eye Glasses & Contact Lens
Davis Vision Client Code 8609
www.davisvision.com; 1-800-999-5431

Life, Accidental Death & Dismemberment and Death Benefits are insured benefits.
MetLife ……. Member Life Insurance, Accidental Death & Disability
MetLife Claims
P.O. Box 6100
Scranton, PA 18505-6100
1-800-638-6420

IMPORTANT NOTICES

TRUSTEES' AUTHORITY and DISCRETION

The Trustees of the Fund have broad authority and discretion to interpret and apply the provisions of the Plan of Benefits including, but not limited to, determination of eligibility for benefits and the right of individuals to participate in the Fund, the manner in which contributions are credited, the level of benefits and the extension or discontinuance of benefits.

LIMIT of AUTHORITY of NON-TRUSTEES

The Plumbers and Gasfitters Local No. 12, any of its Officers, Business Agents, employees or members, any Employer or Employer Association, Fund Office employee or consultant is authorized to speak for or to commit the Board of Trustees of this Fund on any matter without express written authority from the Board of Trustees.

TRUSTEES' RIGHT to AMEND, MODIFY or DISCONTINUE BENEFITS AT ANY TIME

The Trustees reserve the right to amend, modify or discontinue all or part of this Fund whenever, in their judgment, it is desirable or necessary. Benefits, eligibility rules, and other provisions may change after the date of this booklet. Benefits are not vested. Contact the Fund Office regarding current benefits.

YOUR RESPONSIBILITY for SELECTION of PROVIDERS

The selection of medical professionals and service providers is your responsibility. **The Board of Trustees disclaims any responsibility for the qualification or action of any provider of goods or services.**

FOREIGN LANGUAGE ASSISTANCE / SI NO HABLA INGLES

If you do not understand English and have a question about the benefits or the rules of the Fund, contact the Fund Office for assistance.

Si usted no entiende ingles o si tiene una pregunta acerca de los beneficios o las reglas del Fund, llame la Oficina del Fund para asistencia.

CHECKLIST OF YOUR OBLIGATIONS UNDER THE PLAN

To assist you in using the Plan, whether or not you have a claim for benefits, here is a short summary of what you need to do. Complete instructions for using the Plan are contained in the booklets provided by your Insurers.

PROVIDING THE PLAN WITH INFORMATION ABOUT YOU AND YOUR DEPENDENTS

- Complete an enrollment form and designate a beneficiary for your death benefits. (Sec. 1 and Sec. 9)
- Notify the Fund if: (1) your address or telephone number changes; (2) there is a change in family status, such as a divorce or legal separation; (3) the residence of a family member changes; or (4) there is other insurance for you or a family member. (Sec. 14)
- Supply any documents requested by the Plan such as birth certificates, marriage certificates, divorce decrees, Child support orders, court orders etc. (Sec. 1)

APPROVALS REQUIRED BEFORE CERTAIN BENEFITS OR SERVICES ARE OBTAINED

- Contact the Insurer before you receive certain medical services, including inpatient non-Emergency Medical Care (including maternity care). If you do not contact the insurance company in advance to verify network coverage, services may not be covered. (Sec. 3)

WHEN TO USE AN IN-NETWORK PROVIDER

- You may use any Provider you select for dental services; however, Altus Dental has negotiated contracts for these services with In-Network Providers that may save you and the Plan money. (Sec. 7)
- If you are enrolled in a Medicare supplement plan, you are eligible for services under the terms and conditions of Medicare. (Sec. 12)

WHEN COVERAGE TERMINATES

- Contact the Fund within 60 days in the event of enrollment in Medicare, divorce or legal separation or when a Child no longer satisfies the Fund's definition of "Child." (Sec. 21 (B), SECTION 14)
- To purchase continuation coverage under the Plan (COBRA) after eligibility terminates, you **must** complete your election and pay the required premium on time. (Sec. 14, (VI))
- To convert your group term life insurance when your coverage is reduced or terminated, you **must** apply for conversion coverage within 31 days of the day your coverage terminates. (Sec. 9)

SUMMARY PLAN DESCRIPTION
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INTRODUCTION

This booklet is a Summary Plan Description ("SPD") of your Medical and related benefits. These benefits have been established by the Trustees of the Plumbers' Union, Local No. 12 Welfare Fund (the "Trustees") and are provided mostly through the purchase of insurance contracts, but prescription drug benefits and some ancillary benefits are self-funded. The Medical and Dental benefits are insured by the insurance companies with which the Trustees have contracted. This booklet outlines the benefits provided by the Fund, and explains the eligibility requirements, termination of coverage provisions and your legal rights, as determined under the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time. However, a more detailed description of your Medical and Dental benefits is provided in the benefit booklets provided by the Insurers.

Do not rely on this SPD, alone for a description of the benefits available to you and your family. Please see the benefits booklets provided by the Insurers, identified in this SPD, for a full description of your benefits.

This SPD merely provides an outline of the benefits available under the Plan. The benefits booklets provided by the Insurers give you a full description of what benefits are available to you and your family, including the limitations on your benefits.

This SPD is designed to give you a general outline of the Fund's provisions and to help you understand the overall design of the Plan of Benefits, including:

- Eligibility requirements,
- Procedures to be followed to protect your benefits, and
- Your rights under the law and pursuant to the terms of the Plan of Benefits.

Your rights, your responsibilities and the benefits you can expect as a participant in the Plan are very important to you, personally, and to your dependents. That is why we urge you and your family to read this booklet carefully and to keep it in a convenient place for future use as a reference.

PLEASE NOTE: Whenever "he," "him" or "his" appears in this document it shall be construed to include the feminine gender. The words used in this document shall be construed to have their common meanings as found in the dictionary unless defined herein.

SECTION 1. ELIGIBILITY

An individual will become a Participant in the Fund as described below, provided that he completes an enrollment form and submits it to the Fund Office as described in paragraph (1)(2)(3), in Section I., below.

I. ELIGIBILITY RULES FOR EMPLOYEES

A. INITIAL ELIGIBILITY

1. An Employee becomes eligible for coverage the first day of the month following receipt by the Fund of at least 300 hours of contributions on his behalf in a three consecutive month period. In addition, the Fund must have received contributions on his behalf in each month of such three consecutive month period and the Employee has completed all necessary enrollment forms.

2. An Employee in Covered Employment may also establish initial eligibility on a self-pay basis. The Employee may pay up to 100 hours per month at the highest current contribution rate, then in effect, for Employers. Such Employee will be eligible for benefits the first day of the next month after receipt of three months of Employer contributions and self-pay contributions totalling at least 300 hours of contributions on his behalf and the Participant has completed all necessary enrollment forms. *This self-payment provision shall be applicable only to establish initial eligibility for employees who never previously participated in the Plan and not for any other purpose.*

3. The initial eligibility requirement will be waived for any new Employee provided his or her prior health benefit coverage, which must have been in effect during the 6 months immediately prior to becoming employed, is comparable to that provided under Class A health coverage. Coverage will commence after the Employee commences employment and completes all necessary enrollment forms. The Participant must provide a certificate of coverage from the prior insurer. The certificate should disclose the effective date of the prior insurance and state the date the coverage will terminate under the policy. The Trustees will determine whether the coverage is comparable in their sole discretion.

4. An Employee who establishes initial eligibility will remain eligible through the end of the coverage period in which he first became eligible.

B. CONTINUING ELIGIBILITY

1. An eligibility period is a six-month period beginning on any February 1 or any August 1.
2. A coverage period is a six-month period beginning on any March 1 or any September 1.
3. An Employee will be eligible for coverage through each coverage period if his credited hours for the preceding eligibility period (period when actual hours were worked) total 600 or more. Surplus hours in excess of 600 in any eligibility period will be credited to the Employee's Hour Bank according to the Hour Bank rules found, below, in Paragraph C of this Section 1. The eligibility of an Employee whose credited hours falls short of 600 will be determined as follows:

    a. If the Employee is eligible on the day preceding the next coverage period, his eligibility will be continued from the first day of such coverage period for one month for each full 100 hours of his credited hours.

    b. If the Employee is not eligible on the day preceding the next coverage period, his credited hours will not serve to continue or reinstate his eligibility in such coverage period.

EXAMPLES

600 Credited Hours for a six-month <u>Eligibility Period</u>	**Gives Full Coverage throughout month <u>Coverage Period</u>**
February 1, 2019 to July 31, 2019	September 1, 2019 to February 29, 2020
August 1, 2019 to January 31, 2020	March 1, 2020 to August 31, 2020
February 1, 2020 to July 31, 2020	September 1, 2020 to February 28, 2021

4. If an Employee has at least one credited hour but less than 100 credited hours in any Eligibility Period month he may self-pay up to the 100 hours necessary for that **one month** of coverage at the highest current contribution rate, then in effect, for Employers before becoming COBRA eligible or reinstating coverage through eligible Employer contributions.

Example

Eligibility Period Credited Hours	Coverage Period Accrued	Potential Self-Pay Hours	Rate	Self-Pay Total
600	6 months	N/A	$13.57	N/A
580	5 months	20 hours	$13.57	$271.40
190	1 month	10 hours	$13.57	$135.70
330	3 months	70 hours	$13.57	$949.90

C. HOUR BANK

When an Employee accumulates surplus hours in excess of 600 hours during an eligibility period, the surplus hours are credited to his Hour Bank. The maximum number of hours that he may accumulate in his Hour Bank is limited to 600 hours. Once he is eligible, he may draw from the Hour Bank during future eligibility periods the number of hours necessary to maintain eligibility if he does not have the required 600 hours contributions made on his behalf for continued eligibility of benefits.

D. HOURS CREDITED DURING DISABILITY

If, after an Employee becomes eligible for benefits under this Section 1, he is unable to work in Covered Employment because of a disability (illness or injury on or off the job), he will be credited, for the purpose of maintaining eligibility, with 30 eligibility hours for each full week of such disability. Only 780 such hours will be credited in one continuous 12-month period. An Employee must submit medical evidence satisfactory to the Trustees to establish that he is totally disabled or evidence that he is receiving benefits under the Workers' Compensation Act as a result of a disability incurred while engaged in Covered Employment.

Continued certifications of an injury or illness will be required.

Periods of disability due to the same or related causes will be considered one period of disability unless they are separated by at least two consecutive weeks of active work for which contributions are made on his behalf to the Fund. Successive periods of disability due to entirely unrelated causes will be considered one period of disability unless the Employee has returned to active work. An Employee must be receiving regular care or treatment by a licensed, board certified medical doctor in order to be receive these credited eligibility hours. **For hours to be credited during a period of disability, the injury or illness must have been incurred during the last six months before the Fund was notified of the disability. It is an employee's responsibility to advise the Fund Office of disability.**

All claims for weekly accident-sickness benefits pursuant to Section 10 must be filed in writing on the form provided by the Fund Office.

E. ELIGIBILITY FOR MEDICARE BASED UPON AGE

1. Participants Who Are No Longer Employees

When a Participant who is no longer an Employee turns 65, he is entitled to participate in Medicare Parts A, B & D (relevant to coverage in the Fund under Section 11,12); the Participant is automatically enrolled in Part A, which covers hospitalization, when he turns 65, but he must enroll in Part B, which covers medical providers, and which requires a monthly premium based on income. It is not necessary for the Employee to enroll in Medicare Part D, which covers prescription drugs, because the Fund provides this coverage. In addition, the Employee may purchase a supplement to Medicare such as Medex, AARP, or Local 12's Medicare Supplemental Plan.

Since he is no longer an Employee, these programs will provide his medical coverage. Medicare Parts A & B will cover 80% of his covered expenses. The Medicare supplemental plans, mentioned above, should cover the 20% copayment after Medicare's 80% coverage.

If the Participant does not elect to take Local 12's Medicare Supplemental Plan, he may also be eligible for Class C coverage.

Effective September 1, 2013 through August 31, 2023, if such a Participant becomes eligible for Medicare based on age *and* has had 12,000 hours contributed on his behalf in the 10 consecutive years or 18,000 hours contributed on his behalf in the 15 consecutive years immediately preceding his eligibility for Medicare, the Employee and his Dependents may become eligible for **Class C** coverage instead of his current coverage, if he does not elect the Medicare Supplemental Benefit. Please Note: Even if coverage in the Plan continues, **Dental Benefits, Certain Death Benefits, Accident and Sickness Benefits will terminate on the last day of the sixth month following the month in which he ceases to be eligible in the Fund based on contributions.**

2. Employees

If an Employee continues to work after age 65 and is covered under the Plan, he may elect to retain his present coverage or choose coverage under Medicare. Please note: If the Employee elects Medicare coverage, he will be rejecting medical coverage under this Plan with respect to items and services covered by Medicare. This Plan will not provide any supplemental coverage with respect to Medicare covered

services, except as described in the following paragraph for Employees working for small Employers with less than 20 employees.

If the Employee elects to continue coverage under this Plan, his benefits will be paid the same as any other Participant, except that if his Medicare eligibility is based upon age and he is currently employed by an Employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year, then Medicare coverage will be primary and the Plan will pay secondary supplemental coverage to Medicare. The combined primary Medicare payments and supplemental plan payments shall not exceed the reasonable and customary charges for such treatment, and the Plan's supplemental coverage shall be subject to all Plan rules and limitations, including but not limited to copayments and deductibles.

F. TERMINATION

An Employee's coverage will terminate on the earliest of the following dates:

- The date the Plan terminates;
- The date the Employee's Credited Hours and the hours in his Hour Bank, combined, are insufficient to continue his eligibility for another full month; an Employee whose eligibility would otherwise terminate due to the lack of hours, may be able to continue his coverage pursuant to "COBRA"- Continuation of Coverage (see Section 14, below);
- The date the Employee dies, or
- The date the Employee fails to make any required self-pay payments (see Section 14, below, regarding "COBRA"- Continuation of Coverage).

G. WORKING ON TRAVEL CARD

An Employee working on a travel card issued by the Local will continue to be covered when the out-of-town local in whose jurisdiction he is working makes payment to the Fund under a reciprocal agreement. However, where no such reciprocal payments are made, the employee will be offered "COBRA"- Continuation of Coverage (see Section 14, below).

H. COVERAGE AFTER RETIREMENT

1. Regular Retirement

Effective September 1, 2013 through August 31, 2023, Class A coverage, less dental benefits, has been made available to Employees who retire under the Plumbers' Union, Local No. 12 Pension Fund on or after September 1, 2000, after attaining age 55 are eligible for coverage in the Fund. Participants who retire on or after September 1, 2003, also must have had 12,000 hours contributed to ***this Fund and the Pension Fund*** on their behalf

in the 10 consecutive Plan Years immediately prior to retirement or 18,000 hours contributed to ***this Fund and the Pension Fund*** on their behalf in the 15 consecutive Plan Years immediately prior to retirement in order to be eligible. For the purposes of the foregoing provision, hours credited shall be actual hours contributed by a contributing Employer to the Fund on the Participant's behalf and 30 hours per week for each week that an Employee is disabled and 100 hours per month for each month the Participant has made contributions to the Fund under the self-pay provisions of Paragraph I (A), (B)(4) of Section 1 and Section 14, below regarding "COBRA" – Continuation of Coverage.

For purposes of determining the self-pay hours that may be credited toward satisfying the 12,000-hour requirement stated in this 11 an eligible Participant will not be able to retroactively purchase such self-pay coverage when he/she retires. Only continued coverage, purchased under the Plan's self-pay provisions and purchased at a time permitted by the Plan to maintain continued eligibility, will be counted for the purpose of the 12,000 or 18,000-hour requirements.

2. Disability Retirement

An Employee who has met the requirements for a disability pension under the Plumbers' Union, Local No. 12 Pension Fund and who has been credited with contributions to ***this Fund*** of at least 12,000 hours over the 10 consecutive Plan Years immediately preceding such disability pension, may be eligible to continue coverage in the Fund.

The eligible Employee must pay a monthly premium, which has been established by the Trustees for such coverage. This coverage will continue, subject to all other Plan rules, until the Participant reaches Medicare eligibility based upon age (See Section 1 (I)(E) and Section's 11,12 of this SPD regarding Benefits for Participants who are Eligible for Medicare).

Eligible spouses and dependent children may continue coverage provided the monthly payments are made to the Fund Office. This monthly premium is subject to change by the Trustees.

3. Disability Retirement Under Age 55

Effective September 1, 2013 through August 31, 2023, an eligible participant who has met the Plan's requirements for a disability pension under the Plumbers' Union Local No. 12 Pension Plan, and who has been credited with contributions to the Fund of at least 12,000 hours over the last 10 consecutive Plan Years or 18,000 hours over the last 15 consecutive Plan years immediately preceding such disability pension may be eligible to continue Class A coverage, less dental benefits. Coverage for the participant's spouse and eligible dependents is only available if the

contributions COBRA enrollment or self-payments were based upon family coverage for the entire 12,000 or 18,000 hours. For the purposes of the foregoing provision, hours credited shall be actual hours worked for a contributing employer to the Fund, the crediting of 100 hours per month for each month the participant has made self-pay contributions to the Fund under COBRA or the self-pay provisions of I (A), (B)(4) of SECTION 1 and 14 of this Plan and participation through COBRA payments during said period (See COBRA – Continuation of Coverage).

An eligible Employee who is under the age of 55 and who retires on a disability pension may continue coverage by paying 50% of the full cost of coverage plus a 2% administrative fee for the first 29 months of coverage. On the 30th month of continued coverage the eligible Participant will be required to pay the full amount as set forth by the Trustees.

The Trustees reserve the right to amend, alter, or repeal these provisions and terminate such retiree coverage in their sole discretion at any time.

I. CONTINUATION OF HEALTH COVERAGE UPON MILITARY SERVICE

The Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 continues the protection of civilian job rights and benefits for veterans and members of reserve components. If an Employee is absent from employment due to service in the United States Armed Forces, he and his eligible Dependents may be eligible to continue medical coverage under this Fund on a self-pay basis for the period of your military service (to a maximum of 36 months). Please contact the *Fund* Office for additional information.

If you are inducted into military service with the Armed Forces of the United States of America, or voluntarily enlist into military service (including part-time National Guard service or a reserve component of the Armed Forces), your health coverage under this Fund will be continued, as follows: If your military leave is for 31 days or less, health coverage for you and any covered Dependents will continue during your military leave period. If your military leave is longer than 31 days, your eligibility for coverage will be suspended during your period of military service. However, you may elect to continue your coverage for up to 24 months by paying its full cost as determined under COBRA. Your Dependents covered under the Plan will also be eligible to elect to continue health coverage for up to 36 months under the Fund's COBRA provisions by making the required self-payments.

An Employee in the reserves who returns from active duty is entitled to resume eligibility under this Plan if

- the Employee returns to active covered employment within 90 days of the date of the participant's discharge;
- originally left the employer from other than a temporary position; and
- was released from active duty under "honorable" conditions.

USERRA requires this 90-day grace period as a protection for members for the duration of the reserve call-up or any other type of military service for up to five (5) years. The Fund is not obligated to offer this 90-day period to Participant serving in the military for five (5) or more years.

II. ELIGIBILITY RULES FOR DEPENDENTS

Eligible Dependents shall be:

- An Employee's Spouse
- A Participant's Children under 26 years of age (and, until September 1, 2014, for children over 18, only, who do not have employer-sponsored health care available to them other than through a parent).
- A Participant's Children over age 26 incapable of earning his own living and dependent upon the Participant for support and maintenance due to a disability.

A. INITIAL ELIGIBILITY

Eligible Dependents may become eligible for benefits on the Employee's first day of eligibility for benefits if all necessary documentation is received by the Fund Office. If the necessary documentation is received after the Employee's first day of eligibility, the Dependent's eligibility will be the first day of the month following the receipt of the necessary documentation. Newborns are covered from the day they are born, provided the eligible Participant presents the valid birth certificate to the Fund Office within one year of the Child's birth.

1. Documentation

The following documents must be received by the Fund Office before a Dependent will be eligible for coverage:

- Marriage Certificate, for a Dependent Spouse;
- Birth Certificates for your natural Children showing both parents' names;
- A certified or attested copy of the legal adoption of a Child by a Participant;
- A certified or attested copy of the court order, from a court of competent jurisdiction, appointing the Participant guardian of a Child;
- A certified or attested copy of the court order, from a court of competent jurisdiction, placing a Child with the Participant for adoption;
- Documentation and medical records showing proof of a mental or physical disability of a Child over age 25, because of which the Child is unable to be self-supporting; such documentation should be submitted to the Fund Office prior to or within 31 days after the attainment of age 26.

B. CONTINUING ELIGIBILITY

Eligible Dependents may continue to be eligible for benefits if the Employee remains eligible for benefits if all necessary documentation to maintain eligibility is received by the Fund Office. Proof of the continued existence of mental or physical disability that is the cause of the inability of a Child over the age 25 to be self-supporting shall be furnished to the Fund Office upon request.

1. Dependent's Coverage After Participant's Death

Effective September 1, 2013 through August 31, 2023, if the Participant dies at a time when he has been credited with contributions to the Welfare Fund of at least 12,000 hours over the last 10 consecutive Plan Years or 18,000 hours over the last 15 consecutive Plan years immediately preceding death, his eligible dependents may be eligible to continue Class A coverage, less dental benefits. Coverage for the participant's spouse and eligible dependents is only available if the contributions COBRA enrollment or self-payments were based upon family coverage for the entire 12,000 or 18,000 hours. For the purposes of the foregoing provision, hours credited shall be actual hours worked for a contributing employer to the Fund, the crediting of 100 hours per month for each month the participant has made self-pay contributions to the Fund under COBRA or the self-pay provisions of (B)(4) of Section 1 and Section 14 of this Plan and participation through COBRA payments during said period (See COBRA – Continuation of Coverage). If eligible, coverage is available provided the Spouse and/or eligible Dependent makes monthly payments to the Plan (these amounts are subject to change at the discretion of the Trustees), the coverage for such dependents will continue as follows:

a. Pre-Medicare Coverage:

1) For the Spouse: Coverage will continue until the date he/she remarries or becomes eligible for Medicare. In circumstances where the Spouse is eligible for Medicare on the date of the Employee's death, the Spouse will be covered until the next open enrollment period for Medicare.
2) For a Dependent Child: Coverage will continue until the date the Spouse who retains custody of the Child remarries, or if earlier, the date the Dependent Child no longer meets the requirements for coverage or enrolls in other group health coverage.

b. Post-Medicare "Special Retiree" Coverage:

1) For the Spouse, only: Special Retiree coverage will continue for the Spouse of a Special Retiree Participant, who was also covered by the Special Retiree Benefit, until the next open enrollment period of Medicare supplemental coverage. The Spouse may be eligible, at a monthly premium, for the Local

12 Medicare Supplemental Plan. Call the Fund Office for details.

2. Divorced Spouse of Participant

For as long as the benefits described herein are fully-insured, coverage by the Plan for a Spouse who is divorced from an Employee will remain in effect as if said judgment of divorce had not been granted for as long as the Employee remains eligible in the Plan, remarries or until the ex-Spouse remarries. If so ordered in the judgment of divorce, the ex-Spouse's coverage may continue after the *Employee* remarries, in which cased, the Plan may charge an additional premium to the ex-Spouse. The Employee or ex-Spouse must provide the Fund with the divorce judgment and/or support order in order for the former spouse to be covered by the Fund. The Employee or ex-Spouse must notify the Fund Office within sixty (60) days after one of them remarries. After such notification the ex-Spouse will be eligible to elect COBRA continuation of coverage. If the Employer or ex-Spouse fails to notify the Fund Office within sixty (60) days of the date of remarriage, the ex-Spouse will then forfeit any right to elect COBRA continuation coverage under the Plan.

C. TERMINATION

An Eligible Dependent's coverage will terminate on the earliest of the following dates:

- The date the Plan terminates;
- The date the Employee is no longer eligible for coverage; an Eligible Dependent whose eligibility would otherwise terminate, may be able to continue his coverage pursuant to "COBRA"- Continuation of Coverage (see Section14, below);
- The date that an Eligible Dependent no longer meets the requirements to be eligible for benefits as a Dependent; an Eligible Dependent whose eligibility would otherwise terminate, may be able to continue his coverage pursuant to "COBRA"- Continuation of Coverage (see Section 14, below);
- The date a Dependent Child over age 25 who is unable to be self-supporting because of a disability meets the criteria for coverage in a public program or group health insurance plan (not when they receive such coverage or apply for it);
- The date a Participant who is not employed by a contributing employer attains Medicare eligibility;
- The date the Employee or the Dependent fails to make any required self-pay payments (see Section 14, below, regarding "COBRA"- Continuation of Coverage).

A Participant must immediately notify the Plan Administrator in the event the following:

- Divorce;
- Prior to September 1, 2014, access to group health coverage, other than through a parent, by a Dependent Child under age 26;
- A Participant's appointment as a child's legal guardian is no longer effective, is revoked or modified, or if, for any reason, the Participant is no longer the legal guardian of such child.

SECTION 2. COVERED BENEFITS

The Trustees have entered into several arrangements with Insurers to provide coverage for medically necessary services. Premium payment for Participants and eligible Dependents is made by the Fund on your behalf from contributions made on your behalf by your employer as a result of collective bargaining agreements negotiated between Local 12 and various employers and employer associations. This section is intended as a general statement of the benefits available to a Participant.

A full description of the benefits available under each benefit options are provided in the benefits booklets provided by the Insurers. See Addendums Section below.

For information related to your benefits under the Plan please refer to the contact information for the Insurers of each type of benefit at the front of this SPD (p. vi).

The benefits available to Participants are also subject to the terms and conditions outlined in this SPD; for instance, see Section 13, "General Exclusions" for a listing of benefits that are not covered under any arrangement with any Insurer; see also Section 18, "Coordination of Benefits;" under certain circumstances another insurer will be responsible for the payment of your benefits. If there is a discrepancy between the terms of this SPD and the benefits listed in the benefits booklets distributed by an Insurer, the Insurer's benefits booklets will govern.

A. COVERED SERVICES

Coverage is provided only when:

1. The treatment is received by an eligible Participant,
2. The treatment is medically necessary,
3. The treatment conforms to the plan of benefits in effect at the time of treatment (please see benefits booklets distributed by Insurers for any special limits or exclusions from coverage), and

B. MATERNITY CARE

The Plan provides coverage for all medical care related to pregnancy and childbirth (or miscarriage) for any female Participant. See the benefits booklets provided by the Insurers for specific conditions and limitations of coverage.

****SPECIAL NOTE REGARDING THE NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT ("NMHPA"):** Under federal law, this Plan may not restrict the length of hospital stay in connection with childbirth for mothers or newborns to less than forty-eight (48) hours for normal deliveries and ninety-six (96) hours for cesarean sections. The Plan also cannot require a Provider to obtain pre-authorization for maximum lengths of stay. However, pre-authorization is still required from BCBSMA in order to avoid a penalty if receiving services at an Out-Of-Network facility or from an Out-Of-Network Provider. The minimum lengths of stay (i.e., the forty-eight [48] or ninety-six [96] hours) do not apply in any case where the decision to discharge the mother or newborn any earlier is made by the Provider in consultation with the Mother.

C. POST-MASTECTOMY COVERAGE

The Plan covers post-mastectomy coverage under its arrangement with insurer BCBSMA for 1) reconstruction of the breast on which the mastectomy was performed, 2) surgery and reconstruction of the other breast to produce symmetrical appearance, 3) prostheses and, 4) physical complications at all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Contact the Fund Office for further information.

****SPECIAL NOTE REGARDING THE WOMEN'S HEALTH AND CANCER RIGHTS ACT ("WHCRA"):** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and Co-Insurance applicable to other medical and surgical benefits provided under this Plan as described in the benefits booklets provided by the Insurers.

SECTION 3. MEDICAL BENEFITS

The Trustees have entered into a fully insured arrangement with Blue Cross Blue Shield of Massachusetts HMO Blue New England **(BCBSMA)** in order to provide medical and prescription benefits to its Participants, including Eligible Retirees who are not eligible for Medicare. The general description of your coverage is outlined below, but for a full description of your medical and prescription benefits please refer to the benefit booklets provided by Blue Cross Blue Shield of Massachusetts and the Addendums Section below.

A. PROVIDERS OF SERVICE

The Participating Providers in the Insurer's network have agreed to accept negotiated payments for services provided to Participants, otherwise known as the "Allowed Charge." A complete list of Participating Providers can be found in the provider directories distributed by the Insurer or on the Insurer's website. There are also provider directories on file in the Fund Office. Since these directories of Participating Providers are periodically updated with additions and deletions, you should contact your Insurer to get up-to-date information.

B. BASIC CONDITIONS OF PAYMENT

The basic conditions of coverage are outlined, below. ***However***, in order for you and your family to receive the maximum level of benefits under this Plan of Benefits, you must use the procedures outlined in the benefits booklet provided by your Insurer.

1. HMO BENEFITS

Participants residing in Massachusetts, Connecticut, New Hampshire, Maine, Vermont and Rhode Island will be automatically enrolled in the insurer's HMO (Health Maintenance Organization) product. Participants enrolled in the HMO are required to designate a primary care physician. You may find a primary care physician by referring to the **BCBSMA** Website or by calling its member services line at 800-241-0803. This primary care physician will coordinate participant medical care and make the necessary referrals for medical specialists. Participants are responsible for any charges for non-HMO network services or charges over the Plan or insurer's benefit maximums (such as an annual limit on the number of visits to a chiropractor that will be covered by the insurer) *and* for all charges for services that are not covered by the Plan. The amounts of the Deductibles, Co-Payments and Co-Insurance can be found in the benefits booklet provided by the Insurer. Please see the Addendums Section below.

2. PPO BENEFITS

Participants residing **outside of** Massachusetts, Connecticut, New Hampshire, Maine, Vermont or Rhode Island will be automatically enrolled in the insurer's PPO product. Participants enrolled in the PPO are not required to have a primary care physician however they should use in-network service providers. When out of network services are used Participants will be subject to balance billing. Balance billing is the difference between the in-network fees for services negotiated and paid by the insurer to network providers and non-negotiated, out of network billing received by the insurance company. Participants are responsible for any charges for non-network services or charges over the Plan or insurer's benefit maximums (such as an annual limit on the number of visits to a chiropractor that will be covered by the insurer) *and* for all charges for services that are not covered by the Plan. You may find additional information by referring to the **BCBSMA** Website or by calling its member services line at 800-241-0803. The amounts of the Deductibles, Co-Payments and Co-Insurance can be found in the benefits booklet provided by the Insurer. Please see the Addendums Section below.

3. PRIOR AUTHORIZATIONS

Certain Covered Services medical treatment and prescriptions require prior approval by the Insurer. Please review the specific coverage provisions in the benefits booklet provided by BCBSMA Plan. See the Addendums Section Below.

4. DEDUCTIBLES AND COINSURANCE

For all benefits provided by the Fund, a Deductible will apply. Please see Section's 3 and 5, regarding Deductibles and Deductible Reimbursement. For Out-Of-Network benefits, an additional Deductible and Co-Insurance will apply. Specific amounts are provided in the benefits booklet provided by the Insurer. See Addendums Section Below.

General Deductible Information:	
Deductible	**Member Share**
The Deductible applies to all services except where specifically noted in the insurer schedule of benefits.	$250 per Member per Plan Year $500 per family per Plan Year
Deductible Rollover	
	None
Out-of-Pocket Maximum HMO	
Includes all Member Cost Sharing	$2,000 per Member per Plan Year $4,000 per family per Plan Year
Out-of-Pocket Maximum PPO	
Includes all Member Cost Sharing	$4,000 per Member per Plan Year $8,000 per family per Plan Year

SECTION 4. PRESCRIPTION DRUG BENEFIT

1. The Fund insures its prescription drug benefit through its arrangement with BCBSMA. Your BCBSMA member ID card also serves as your prescription benefit card. See the Addendums Section Below.

2. Participants who take maintenance drugs used for chronic ailments such as high blood pressure, heart conditions, diabetes, etc., which requires taking medication for a long period of time, can receive by mail-order a **three month/90-day supply**. Contact BCBSMA at 800-241-0803 or mail order pharmacy benefit manager Express-Scripts at www.express-scripts.com. Please refer to the Addendums Section Below.

	Retail (up to a 30-day supply)	Mail (up to a 90-day supply)
Tier 1	$5 Copayment	$10 Copayment
Tier 2	$20 Copayment	$20 Copayment
Tier 3	$40 Copayment	$40 Copayment
Tier 4	$60 Copayment	$60 Copayment

3. Diabetes Program. The Trustees have engaged **Abacus Health Care** to administer a free Diabetes medication program. Eligible Participants and Dependents following the Abacus program may be eligible for **free diabetes Medication** and Supplies. Call Abacus at **800-643-8028.** Please see the Addendums Section below for additional information.

SECTION 5. MENTAL HEALTH & SUBSTANCE ABUSE

A. For Mental Health and Substance Abuse Services you should call BCBSMA at **1-800-444-2426**. The Plan covers both inpatient and outpatient mental health care to the extent medically necessary as outlined in the Insurers benefits booklet. As used in this section the term "mental health care" includes the medically necessary treatment of substanceabuse disorders as defined in the Insurer's (BCBSMA) benefits booklet.

For coverage of mental health care (including the treatment of substanceabuse disorders), you should call BCBSMA at **1-800-444-2426**.

In a Medical Emergency you or your Dependent should go to the nearest emergency facility or call 911 or your local emergency number.

The Insurer(BCBSMA) requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of medical necessity for mental health care will be made in consultation with a licensed mental health professional.

B. The Trustees have engaged Modern Assistance Programs, Inc. (MAP) to provide an Employee Assistance Program. This service is designed to complement the fully insured mental health and substance abuse coverage offered by the Insurer (BCBSMA). When necessary MAP will coordinate care with your mental health and substance abuse benefits available through the Insurer (BCBSMA).

Members of Local 12 and their families are encouraged to use MAP. MAP is a Massachusetts cutting edge provider of Employee Assistance Programs dealing with family and workplace crisis. What is a family crisis? Family crisis's come in many forms. There is no single definition or list to reference.

If you or a family member is facing a difficult situation, whatever it may be, MAP can help. It's simple just call **617-774-0331 or 1-800-878-2004**. Resources are available 24 hours a day seven days a week.

In a Medical Emergency you or your Dependent should go to the nearest emergency facility or call 911 or your local emergency number.

SECTION 6. DEDUCTIBLE REIMBURSEMENT

As of September 1, 2020, the Trustees have made arrangements with Welfare Plan insurer Blue Cross Blue Shield of Massachusetts to reduce the Annual Deductible for an Individual Subscriber from $500 to $250 and from $1,000 to $500 for a Family Subscription. The Plan had previously reimbursed 50% of your annual deductible and with the reduction of deductible by 50% the Plan is eliminating Deductible Reimbursement for claims incurred on or after September 1, 2020.

SECTION 7. DENTAL BENEFITS

The Trustees have entered into arrangements with **Altus Dental** of Massachusetts as Network service provider (the Insurer or Insurers) in order to **provide comprehensive dental benefi**ts to its Participants. Retired participants are not eligible for Dental coverage. Please see the Addendums Section Below. Please call Altus Dental at 877-223-0588 or online at www.altusdental.com to inquire about network providers or with questions you may have on your dental benefits.

A. PROVIDERS OF SERVICE

The Plan will cover services provided by a Participating Dental Provider as well as Non-Participating Dental Providers. A complete list of Participating Dental Providers can be found on the Altus Dental website www.Altusdental.com. If you do not have access to the internet, please call the Fund Office for assistance.

B. BASIC CONDITIONS OF PAYMENT

The basic conditions of coverage are outlined, below. ***However***, in order for you and your family to receive the maximum level of benefits under this Plan, you must use the procedures outlined in the benefits booklet provided by your Insurer.

C. FINANCIAL RESPONSIBILITY OF PARTICIPANTS

Not all services are covered by the Plan and some services are not covered completely. The Plan also limits the coverage for certain services received in

a calendar year (the "calendar year" is listed in the benefits booklet provided by the Insurer and is available from the Fund Office). The Participant is responsible for payment for all of the non-covered services. Specific terms of coverage are provided in the benefits booklet available from the Insurer.

D. CO-INSURANCE

The Participating Dental Providers have agreed to accept negotiated payments for services provided to Covered Participants, otherwise known as the "negotiated charge." The Plan will often only cover a portion of the negotiated charge for specific dental services. The remaining balance, or Co-Insurance, is the responsibility of the Participant. Specific Co-Insurance amounts are provided in the description of benefits booklet available from the Insurer.

E. DISCOUNTS

In certain circumstances, the Plan may only provide for a discount of the negotiated charge for specific dental services. The Participant is responsible for the remainder of the discounted bill. Specific discount amounts are provided in the description of benefits booklet available from the Insurer.

SECTION 8. HEARING AIDS, ACUPUNCTURE & TUINA THERAPY

The Welfare Plan offers limited coverage in a combined maximum coverage of $1,000 for the following:

I. BENEFIT MAXIMUM:

$1,000 Calendar Year Maximum Allowable charge for any one or combination of Hearing Aid, Acupuncture or Tuina Therapy benefits.

II. MENU:

A. Hearing Aids
B. Acupuncture
C. Tuina Therapy

A. **Hearing Aids** - Under the Menu the Plan will allow up to $1,000 per calendar year, per eligible participant, for the purchase of a Hearing Aid(s) device.

a. An Otolaryngologist (ear, nose & throat M.D.) must be consulted in order to establish the medical necessity of a hearing aid device. Documentation of the

medical assessment and the report of the audiologist must be submitted with the claim.

b. The medical testing portion of your treatment should be covered by the Insurer as long as your primary care physician obtains the testing through a referral. You should check the Addendums Section below and call the Insurer (BCBSMA Member Services at **1-800-241-0803)** to verify coverage. Please arrange with your Insurer primary care physician for an Otolaryngologist referral. Most Otolaryngologists have audiologist associates in their office. You should ask if an audiologist is available when making your appointment. An audiologist is not a medical doctor.

    1) There are two forms of hearing loss:

    2) Conductive – A hearing loss due to a problem with the ear canal, eardrum and/or the three bones connected to the eardrum. There are common reasons for this type of hearing loss such as excessive wax or fluid behind the eardrum. Medical treatment or surgery rather than a hearing aid device may be more appropriate for these and other forms of conductive hearing loss.

    3) Sensorineural – A hearing loss problem due to damage to the inner ear or auditory nerve. The cause of sensorineural hearing loss may be due to aging or noise exposure. Medical or surgical intervention cannot correct most sensorineural hearing losses. A hearing aid device may help reclaim some sounds that you are missing as a result of nerve deafness.

    4) Once a Hearing Aid is purchased, that device will not be eligible for replacement for **3 years**. The Plans Hearing Aid benefit will not cover maintenance, repair or the purchase of batteries for a device.

    Example # 1: Bob purchases a Hearing Aid device for his left ear in May of 2019. Bob will be reimbursed the full $1,000 after he forwards the claim along with the testing information from his physician. The device Bob purchased is not eligible for replacement until May of 2022.

    Example #2: Joe purchases a Hearing Aid Device for his right ear in June of 2019. Joe is reimbursed $500 for this device because he has used $500 in Acupuncture through May of 2019. This Hearing Aid device will not be eligible for replacement until June of 2022.

    Example #3: In October of 2020 Dan calls the Fund office to inquire about his eligibility for the purchase of a Hearing Aid. The Fund office explains to Dan that he will not be eligible for coverage until January of 2021. This is because through September of 2020 Dan has used the $1,000 Maximum Allowable Menu charge on a combination of Tuina Therapy and Acupuncture.

    Helpful Information about purchasing hearing aids:

- Ask about all fees related to the purchase of the device. If a physician and his/her audiologist have tested your hearing, testing by the hearing aid vendor should not be necessary. The Plan will not cover testing by Insurer non-network providers.

- Inquire about the trial period, returning a defective device, refund policy, warranty and consumer protection program for hearing aid purchases in your state.

B. **Acupuncture** – Under the Menu the Plan will allow up to $1,000 per calendar year, per eligible participant, for **Eligible Acupuncture Treatment**. Under the Welfare Plan **Eligible Acupuncture Treatment** is defined as treatment used for **Pain Management** applied by a licensed practitioner. If the treatment is not **Pain Management** related it will not be eligible for coverage. An individual licensed as an Acupuncturist in the state in which service is rendered must provide Acupuncture treatment. Claims submitted to the Plan must reference pain management treatment.

Example #1: Between January and December of 2019 Bill visited a licensed Acupuncturist monthly for treatment of migraine headaches. The Acupuncturist fee was $80 for each of Bill's 12 visits. Because Bill used no other Menu benefits and the total amount charged was $960 his services were covered at 100%.

Example #2: Bill's wife Mary visited the same licensed Acupuncturist twice in January of 2020 for smoking cessation treatment. Mary's claim was denied since smoking cessation is not pain management and therefore not a covered under this menu of benefits.

Example #3: Mike visits an unlicensed Acupuncturist for pain management treatment. The Fund office denies Mike's claim due to the fact that the acupuncturist providing the service was unlicensed.

D. **Tuina Therapy** – Under the Menu the Plan will allow up to $1,000 per calendar year, per eligible participant, for **Eligible Tuina Therapy Treatment**. Under the Welfare Plan **Eligible Tuina Therapy Treatment** is defined as treatment used for **Pain Management** applied by a licensed practitioner. If the treatment is not **Pain Management** related it would not be eligible for coverage. An individual licensed as a massage therapist in the state in which service is rendered must provide Tuina Therapy treatment. Claims submitted to the Plan must be specific to Tunia Therapy and reference pain management treatment.

Example #1: Between January and December of 2019 Edward visited a licensed massage therapist for Tuina Therapy monthly for treatment of migraine headaches. The Therapist fee was $80 for each of Edward's 12 visits. Because Edward used no other Menu benefits and the total amount charged was $960 his services were covered at 100%.

Example #2: Tom's wife Helen visited the same licensed massage Therapist for Tuina Therapy twice in January of 2020 for stress relief treatment. Helen's claim was denied since Stress relief is not pain management and therefore not a covered under this menu of benefits.

Example #3: John visits an unlicensed massage therapist for Tuina Therapy for pain management treatment. The Fund office denies Mike's claim due to the fact that the therapist providing the service was unlicensed.

SECTION 9. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

When a covered injury or sickness results in an Employee's accidental death, injury, or illness, the Employee or his beneficiary may be eligible to receive Accidental death and Dismemberment (AD&D) benefits. The Fund has purchased this coverage on behalf of its eligible Participants from MetLife. Please contact the Fund Office if there are any questions relating to this coverage. Please see the Addendums Section Below.

A. ELIGIBILITY

The policy defines an eligible person as one who fulfills the coverage for Class A insurance and in addition to being actively at work employees as defined in the attached Certificate of insurance issued by MET Life to include: (1) all employees of a participating employer covered by a collective bargaining agreement between the participating employer and the Plumbers' Union Local No. 12 or other written agreements that require contributions to be made to the Funds; (2) all employees of any organization established or maintained by the Plumbers' Union Local No. 12; or (3) all employees of any organization established or maintained jointly by the Plumbers' Union Local No. 12 and by a participating employer.

B. ELIGIBILITY RESTRICTIONS

The Person must be covered by the Welfare Plan by virtue of active employment, be actively at work and available for work under the Collective Bargaining Agreement.

C. BENEFITS

The Life and AD&D benefit is for eligible and insured participants under Class A coverage who fulfill the requirements set forth in the attached policy from MetLife.

1. If an individual is an eligible and insured participant under the MetLife Policy effective September 1, 2012 the benefit, the accidental death benefit is payable in the **principal sum of $50,000.00.** Spouses and dependents are not eligible for this benefit.

2. A Self-Insured Death Benefit of $2,500 is provided under the Welfare Plan for Retired members who were or are eligible for health care coverage in retirement according to PART I (H)(1)(2). These retiree death benefits are not covered in the MetLife policy.

3. Eligible accidental dismemberment benefits are outlined in the attached policy from MetLife.

4. No term or condition herein shall supersede the terms of the insurance policy.

D. EXCLUSIONS

The AD&D benefit does not cover any loss resulting from:

- intentionally self-inflicted injury, suicide or attempted suicide, whether sane or insane;
- war or acts of war, whether declared or undeclared;
- injury sustained while in the armed forces of any country or international authority;
- injury sustained while riding on any aircraft except a civil or public aircraft, or military transport aircraft;
- injury sustained while riding on any aircraft:
    - as a pilot, crew member, or student pilot;
    - as a flight instructor or examiner; or
    - if it is owned, operated, or leased by or on behalf
    - of the policyholder, or any employer or organization
    - whose eligible persons are covered under this policy.

No term or condition herein shall supersede the terms of the insurance policy.

SECTION 10. WEEKLY ACCIDENT & SICKNESS

If an Employee is unable to work because of a non-work-related illness or injury, he may be eligible to receive a weekly accident and sickness benefit. **In order to be eligible for this benefit, a Participant must be receiving regular care or treatment from a licensed, certified medical doctor. Call the Fund Office to determine eligibility for this benefit.** A statement of claim form must be completed by your attending physician and returned to the Fund Office in a timely fashion.

A. ELIGIBILITY

In order to be eligible for the weekly accident and sickness benefit described in this section, a Participant must be unable to work because of a non-work-related injury or illness. The Participant must also have been eligible for active benefits immediately prior to such injury or illness. If such eligibility is based on illness, the first weekly benefit will not be paid until after a seven (7) day waiting period has been completed. No benefit will be payable if a Participant applies for such benefits later than the last day of the 6th month following the month in which the Participant ceases to be employed by an employer who contributes to the Plan. **Periods of disability due to the same or related causes will be considered one period of disability unless they are separated by at least two (2) consecutive weeks of active work.**

B. AMOUNT OF WEEKLY BENEFIT

A weekly benefit of **$250** will be payable to a Participant who satisfies the eligibility requirements. Such amount shall be subject to and reduced by any applicable withholding taxes.

a. Termination of Weekly Benefit

Weekly accident and sickness benefits will terminate on the earliest of the following events:

- After the Plan has paid to the Participant **26 weekly payments;**
- The date the Participant dies;
- The date the Participant no longer satisfied the eligibility rules for active benefits;
- The date of the Participant's reemployment;
- The date the Participant is able to return to work, as determined by the Trustees in their sole discretion.

The Trustees have the right to change, limit or discontinue Plan benefits at any time. If the Trustees abolish the Weekly Accident and Sickness Benefit, in whole or in part, the effective date of such amendment is the date in which a Participant's accident and sickness benefits terminate (if such benefits are abolished in whole), or are modified (if such benefits are only reduced).

b. Work Related Injury

If a Participant is unable to work because of a disabling work-related injury, he may be eligible to receive credited hours towards his pension and welfare. **However, Weekly Accident and Sickness Benefits are available for a work-related disability**. See Part 1, Section E, Hours Credited During Disability for more information. Participants who are eligible this benefit must have been eligible for active benefits immediately prior to such work-related injury.

SECTION 11. SPECIAL RETIREE BENEFIT

A. INTRODUCTION

There is a limited benefit for retirees who have retired from Plumbers' Union Local 12 with contributions of at least 12,000 hours over the 10 consecutive years immediately preceding their retirement. This benefit is in no way connected to the Plumbers' Union Local 12 Retiree Medicare Supplemental Plan for which the member pays a monthly premium. Members who participate in Local 12's Retiree Medicare Supplemental Plan CANNOT also participate in this Special Retiree Benefit.

Important: In addition to your Special Retiree Benefit, you may wish to purchase a supplemental policy to Medicare such as Medex or any HMO Senior Plan in order to improve your standard coverage under Medicare.

Please contact the Fund Office if you have any questions.

B. COVERED BENEFITS

1. INPATIENT HOSPITAL

The Special Retiree Benefit will provide you or your spouse with a limited benefit for hospital and inpatient doctor's charges. Like all hospital charges covered by the Plan, there is no benefit for television, radio or telephone costs.

Hospital Benefit – A

Provides a benefit equal to the Medicare inpatient hospital deductible. No more than two such payments are allowed in any one calendar year. The Medicare inpatient deductible is the amount that must be paid in each benefit period before Medicare inpatient hospital benefits begin. A benefit period starts the day you enter the hospital and ends when you have been out of the hospital for 60 days in a row. The amount of the Medicare deductible is subject to change each year.

Hospital Benefit – B

Provides a benefit for inpatient hospital charges that are not covered by Medicare. This benefit pays $12.00 per day for each hospital confinement for up to a maximum of 31 days per calendar year.

2. MEDICAL BENEFIT

This benefit pays the $100.00 Medicare medical deductible and the remaining 20% of allowable charges after Medicare has made its payment. Covered services may include outpatient hospital charges and

doctor's office visit services, surgery, and durable medical equipment (rental and/or purchase which has been allowed by Medicare).

The maximum payment allowed per calendar year for both inpatient doctor's charges and the medical benefit is $350.00.

3. AMBULANCE SERVICES

This benefit pays the 20% of allowable ambulance charges after Medicare has made its payment. The maximum calendar year payment for this benefit is $60.00.

IMPORTANT: After Medicare has paid your medical charges, send all Medicare Explanation of Benefit Statements to the Fund Office for processing.

SECTION 12. MEDICARE SUPPLEMENT

The Trustees self-insure coverage for medical benefits under the Medicare Supplement and insure Medicare Part D Prescription Coverage through provider Benistar. This program provides reimbursement to Participants and their eligible Dependents for some of the co-payments, co-insurance and deductibles that are their responsibility under Medicare. Some additional services and supplies may also be provided to Participants. The specific terms of coverage are provided in the Medicare Supplemental Plan booklet available at the Funds Office. Please see the Addendums Section Below.

A. PROVIDERS OF SERVICES

Participants will receive services under the terms and conditions of Medicare.

B. CONDITIONS OF PAYMENT

Generally, benefits will only be provided for services covered by Medicare. Participants eligible for Medicare must refer to their *Medicare Handbook* for an explanation of benefits available under Medicare and the restrictions that apply. In addition, benefits provided by certain types of providers may not be covered by the Plan. The specific terms of coverage are described in the benefits booklet available from the Funds Office. Please see the Addendums Section Below.

C. DEDUCTIBLES

Medicare may only provide coverage for certain services after the Participant has paid a deductible. The Plan covers the deductible with certain limitations. The Participant is responsible for the non-covered portion of the deductible. The specific terms of coverage are provided in the benefits booklet available from the Funds Office. Please see the Addendums Section Below.

D. CO-INSURANCE

Medicare often only covers a portion of the allowable charge for specific services. The remaining balance, or co-insurance, is covered by the Plan, with certain limitations. The Plan limits the coverage for certain services per policy year (the "policy year" is listed in the benefits booklet provided by the Insurer and is available from the Fund Office) or may not cover certain services at all. The Participant is responsible for all of the non-covered co-insurance. The specific terms of coverage are provided in the benefits booklet available from the Funds Office. Please see the Addendums Section Below.

E. CO-PAYMENTS

Medicare may not begin paying for benefits until a Co-Payment has been paid by the individual. The Plan will pay for the Co-Payment, with certain limitations. All non-covered Co-Payments are the Participant's responsibility. The specific terms of coverage are provided in the benefits booklet available from the Insurer.

SECTION 13. GENERAL EXCLUSIONS

Please refer to the benefits booklets provided by the Insurers for more detailed descriptions of the exclusions from Covered Benefits. However, the Fund does not provide coverage for the following:

1. Nicorette gum and/or other smoking cessation medications/programs not covered under the schedule of benefits with the Fund's Insurers or its arrangement with the Pharmacy Benefit Manager.
2. Non-prescription drugs or medications and over-the-counter medical supplies not covered under the schedule of benefits with the Fund's Insurers or its arrangement with BCBSMA;
3. Nutritional supplements, vitamins, baby formula and weight loss/gain diet programs or medications not covered under the schedule of benefits with the Fund's Insurers or its arrangement with the Pharmacy Benefit Manager;
4. Muscle enhancement drugs not covered under the schedule of benefits with the Fund's Insurers or its arrangement with the Pharmacy Benefit Manager;
5. Contraceptive drugs related to birth control or expenses for the cost, supply, or fitting of contraceptive devices/programs as allowed by law not covered under the schedule of benefits with the Fund's Insurers or its arrangement with the Pharmacy Benefit Manager;
6. Infertility treatments as allowed by law not covered under its contract with the Insurers or its arrangement with the Pharmacy Benefit Manager;
7. Exercise, aerobic and meditation programs not covered under the schedule of benefits with the Insurers;
8. Eyeglasses, contact lenses, vision screening, routine eye exams, hearing aids or exams to prescribe, fit, or change the same; corrective laser surgery not covered under the Insurers' schedule of benefits;

9. Any treatment performed to correct near-sightedness or far-sightedness not covered under the Insurers' schedule of benefits;
10. An injury, illness, or disease suffered while in the military service or resulting from such military service;
11. Any treatment or charge incurred while the covered person is incarcerated in a county, state, or federal prison;
12. Psychiatric services for a condition that is not a mental disorder and not covered under the Insurers' schedule of benefits;
13. Charges for which the Participant is entitled to under any other group medical plan which is primary and is not covered under the Insurers' schedule of benefits or the Fund's arrangement with the Pharmacy Benefit Manager;
14. Any charges which otherwise would be covered, but the Participant has not complied with the Fund's reimbursement procedures;
15. Charges incurred as a result of a court order; such as: drunken driving programs, substance abuse programs, spousal/child abuse counseling programs not covered under the Insurers' schedule of benefits or the Fund arrangement with the Pharmacy Benefit Manager;
16. Medical claims submitted more than one year from the date of service, Weekly Accident and Sickness claims submitted later than the last day of the sixth month following the date the Employee could no longer work in covered employment due to a non-work-related injury or illness and any claims regarding which additional documentation was not received within 12 months from the date such additional information was requested;
17. Any charge exceeding the reasonable and customary charge for such treatment, device or service;
18. Services and supplies as determined by the Trustees not to be covered under the Insurers' schedule of benefits or the Fund's arrangement with the Pharmacy Benefit Manager;
19. Methadone treatment for drug addiction not covered under the Insurers' schedule of benefits or the Fund's arrangement with the Pharmacy Benefit Manager;
20. Blood testing for marriage;
21. Personal comfort items including, but not limited to, telephone, radio, television, air conditioners, saunas, non-prescription items, or personal care services;
22. Special home construction to accommodate a condition, illness, injury or disability;
23. Expense of travel, whether or not prescribed by a physician;
24. Hypnosis, massage therapy and biofeedback not covered under the Insurers' schedule of benefits or the Fund's arrangement with the Pharmacy Benefit Manager;
25. Core evaluations, intelligence testing, services for Chapter 766 eligibility/early intervention services not covered under the Insurers' schedule of benefits or the Fund's arrangement with the Pharmacy Benefit Manager;
26. Custodial care, as determined by the Insurers or the Trustees, including room and board charges in a nursing home, rest home, hospice, old age home or in a school like setting not covered under the Insurers' schedule of benefits;
27. Custodial, education or training, and/or room and board charges in a facility primarily for the treatment of physical or mental disabilities not covered under the Insurers' schedule of benefits or the Fund's arrangement with the Pharmacy Benefit Manager;

28. Charges that the Participant is not required to pay;
29. Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated;
30. Any expenses or charges incurred in connection with sex or gender reassignment or sexual dysfunction not covered under the Insurers' schedule of benefits or the Fund's arrangement with the Pharmacy Benefit Manager;
31. Any hospital, medical or dental treatment, services or supplies payable by an insurance carrier under a compulsory plan of "No Fault" automobile insurance not covered under the Insurers' schedule of benefits or the Fund's arrangement with the Pharmacy Benefit Manager;
32. An illness, injury or disease which the Trustees determine arose out of and in the course of your employment;
33. Child birthing classes and/or breast pumps not covered under the Insurers' schedule of benefits or the Fund's arrangement with the Pharmacy Benefit Manager;
34. Services provided by an immediate family member;
35. Any medical or related prescription charges incurred as a result of committing or attempting to commit a felony or felonious act;
36. Wigs or hair prostheses, unless prescribed due to loss of hair resulting from chemo or radiation therapy;
37. Corrective shoes, back supports, pillows and mattresses not covered under the schedule of benefits with BCBSMA or the Funds Medicare Supplemental Benefit.

MOTOR VEHICLE LIMITATIONS

When a Participant is involved in a motor vehicle accident, the Participant's automobile **no fault insurance carrier** is liable for all medical, surgical, hospital and related charges and expenses up to the first **$8,000** or other applicable no fault limit**.** Once the initial $8,000 (or applicable no-fault limit) has been paid by the no fault insurance carrier and proof has been submitted to the Fund Office, the Plan may begin paying covered medical charges. If at the time of the accident the Participant did not have no fault automobile insurance or any other insurance which would cover the medical costs incurred in connection with a motor vehicle accident, the Participant or his dependent would be considered self-insured and must pay the initial $8,000 of charges incurred. See the "When Third Parties May Be Liable," Section 16, for information regarding claims in excess of $8,000. **The Participant must notify the Fund Office when claims reach the $8,000 maximum. The Participant or the eligible dependent must notify the Fund Office when claims are incurred as a result of a motor vehicle accident. Failure to do so could result in denial of claims.**

SECTION 14. COBRA CONTINUATION COVERAGE

I. IN GENERAL

This Section contains important information about Participants' right to COBRA continuation coverage, which is a temporary extension of health coverage *only* (*i.e.*, medical, hospitalization, dental, and prescription drug coverage) under the Plan on a self-pay basis.

This Section generally explains COBRA continuation coverage, when it may become available, and what Employees and Eligible Dependents need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available when a Participant would otherwise lose group health coverage. It is available to Eligible Dependents when they would otherwise lose group health coverage whether or not the Employee loses coverage.

COBRA continuation coverage is the continuation of the Plan's health coverage for a limited period of time on a self-pay basis when coverage under the Plan would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed, below. After a qualifying event, COBRA continuation coverage must be offered to each Participant who is a "qualified beneficiary." In order to be eligible for COBRA, the Participant must have been eligible for coverage under the Plan at the time of the qualifying event, i.e., the termination of employment or reduction in hours. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. However, Employees may also elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Dependent Children. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

COBRA coverage will generally be the same as the type of coverage the Participant had the day before the qualifying event**.** The type of coverage, however, may be reduced or modified if such coverage is reduced or modified in the same manner to similarly situated beneficiaries under the Plan with respect to whom a qualifying event has not occurred.

The Plan does not provide COBRA contribution coverage of Life Insurance, Accidental Death and Dismemberment, Death or Short-Term Disability benefits, but all other benefits available under the Plan can be continued through COBRA continuation coverage.

For additional information about individuals' rights and obligations under the Plan and under federal law, you should review this SPD and contact the Plan at the address in front of this booklet.

II. QUALIFYING EVENTS

A. A Participant will become eligible for COBRA continuation coverage if he loses coverage under the Plan because one of the following qualifying events happens:

1. Reduced hours of employment; or
2. Employment ends for any reason other than the Employee's gross misconduct.

B. An eligible Spouse will become eligible for COBRA continuation coverage if she loses coverage under the Plan because one of the following qualifying events happens:

1. The Employee dies;
2. The Employee's hours of employment are reduced;
3. The Employee's employment ends for any reason other than his or her gross misconduct;
4. The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The Spouse divorces or legally separates from the Employee and whose coverage is not continued pursuant to the divorce judgment.

C. Dependent Children will become eligible for COBRA continuation coverage if they lose coverage under the Plan because any of the following qualifying events happens:

1. The Employee dies;
2. The Employee's hours of employment are reduced;
3. The Employee's employment ends for any reason other than his or her gross misconduct;
4. The Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The Child no longer meets the eligibility requirements of a Covered Dependent.

In addition, a Child who is born to or placed for adoption with a Participant during a period of COBRA continuation coverage may make an election to continue COBRA continuation coverage, if the Participant elected COBRA coverage and enrolls the new Child upon birth or adoption.

D. You Must Give Notice of Some Qualifying Events

1. You must notify the Fund Office of the following qualifying events—
   - divorce or legal separation of the Employee and Spouse,
   - a Child losing eligibility, or
   - a disability determination (if you wish to extend your coverage for up to 29 months) **and** a determination that you are *no longer* disabled.

2. In order to be eligible to elect COBRA continuation coverage, you must provide this notice ***within 60 days*** of the later of: (a) the qualifying event (including a disability determination during the initial 24-month COBRA period), (b) the date on which you lose coverage due to the qualifying event, or (c) the date on which you are informed, by this SPD or by a general COBRA notice, of your obligation to provide this notice to the Plan Administrator and the procedures for providing this notice.

In regard to disability determinations, in no event can notice be given later than the expiration of the initial 24-month COBRA period.

3. The notices should be sent certified mail to the following address:

Plumbers' Union Local No. 12 Welfare Fund
1230-1236 Massachusetts Avenue
Boston, MA. 02125
Attention: COBRA Notification.

Such notice must include the identity of the Plan, the names of the Employee, the qualified beneficiaries, the qualifying event or determination and the date of the qualifying event or determination.

Once the Fund Office has been so notified, the Fund Office will then respond as described herein. The Plan intends to notify the Participant of the loss of active coverage by first class mail to the last known address on file at the Fund Office. **The Plan has no responsibility or liability to provide COBRA extension of benefits if the Participants do not notify the Plan of a qualifying event, as noted above. It is the Participants' responsibility to contact the Fund Office to verify one of the above qualifying events.**

III. ELECTION PERIOD

Qualified beneficiaries must elect COBRA continuation coverage *within 60 days* of the date they are notified of their right to elect COBRA continuation coverage or the date that their coverage ends, if later.

Qualified beneficiaries must complete and return the election form provided by the Plan Administrator. Coverage under the Plan will be continued under COBRA from the day that coverage would have been lost coverage provided that:

The election form is completed and received by the Plan Administrator within 60 days of the later of:

- The date notice of COBRA election rights was sent, or
- The date coverage was lost due to a "qualifying event," and

The initial required premium is paid to the Plan within 45 days after the date of COBRA election and is thereafter paid when due.

IV. PAYING FOR COBRA CONTINUATION COVERAGE

If you elect COBRA continuation coverage, you are responsible for the payment of the required monthly premium, the amount of which will be provided to you with the election form, as follows;

A. You have 45 days from the date of your election of COBRA continuation coverage to pay to the Plan Administrator the required monthly premiums from the first month that you are required to self-pay for COBRA coverage. **Remember, the first premium payment must cover the period of COBRA continuation coverage for all months for which you must self-pay through the date of the payment**. For example, if you lose coverage as of March 1 and elect to take COBRA coverage on April 15, you have until May 31 to make your first premium payment, but it must cover the period going back to March 1—the date you had to begin to self-pay for COBRA coverage—which is three months.

B. Payment thereafter must be made on or before the first day of each month. You will have a grace period to pay the required monthly premium until the end of the month or 30 days, whichever is longer. Claims submitted during that month will be pended until the Plan receives your COBRA premium.

C. Failure to pay the required monthly premium by the end of the grace period will result in the termination of your COBRA continuation coverage back to the beginning of the month. All claims submitted for services rendered in that month will be denied. Once terminated, your COBRA continuation coverage cannot be reinstated.

D. **Premium for COBRA Continuation Coverage.** You will be notified of the amount of the monthly premium when you receive your COBRA election form. The Board of Trustees will set the amount of the monthly premium according to federal law. The Trustees may only change the COBRA premium annually.

V. HOW LONG IS COBRA COVERAGE AVAILABLE

COBRA continuation coverage is a temporary continuation of coverage for a certain period of time as outlined below:

A. Qualified beneficiaries will become eligible for 24 months of COBRA continuation coverage if they lose coverage under the Plan because:

1. The Employee's hours of employment are reduced; or
2. The Employee's employment ends for any reason other than his or her gross misconduct.

B. Dependents are eligible for COBRA continuation coverage for up to 36 months if eligibility is lost because of:

1. the Employee's death,
2. the Employee's entitlement to Medicare benefits (under Part A, Part B, or both),
3. divorce or legal separation, or
4. a Child no longer meeting the eligibility requirements of a dependent under the terms of the Plan.

C. If an Employee becomes covered by Medicare or has other group health coverage before termination of employment (including retirement), which is a "qualifying event," or before eligibility is lost because of a reduction in work hours, entitlement to Medicare other group health coverage does not cause the Participant to lose COBRA rights.

D. **Eligibility for Extensions:** There are two ways in which the 24-month period of COBRA continuation coverage referred to above can be extended. In no event can the COBRA continuation period be extended for more than 36 months.

1. ***Disability Extension***: If a Participant is determined to be disabled under Title II or XVI of the Social Security Act at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage and the Plan Administrator is notified in a timely fashion, he may be entitled to receive up to an additional 5 months of COBRA continuation coverage, for a total maximum of 29 months. If the Employee is determined to be disabled, his Eligible Dependents would also be entitled to receive the extension. The disability must last at least until the end of the 24-month period of continuation coverage.

   In order to be eligible for this disability extension, notice must be provided to the Plan Administrator within 60 days after (a) the date of the disability determination, or (b) the date on which notice is provided by the Plan, by this SPD or by a general COBRA notice, of this obligation, whichever is later.

   Notice **must** be provided in writing to the Fund Office at the address in the front of this SPD. Such notice must include the name of the Plan, the Employee, the qualified beneficiaries, the disability determination and the date of the determination.

2. ***Second Qualifying Event***: If a qualified beneficiary experiences another qualifying event while receiving 24 months of COBRA continuation coverage, eligible dependents can get up to 12 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to Dependents receiving COBRA continuation coverage because:

   - The Employee dies,

- The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both),
- The Employee and the Spouse get divorced or legally separated and the Spouse's coverage is not continued pursuant to the divorce judgment, or
- The Child no longer meets the eligibility criterion of a Dependent,

The second qualifying event extension is only applicable if the second qualifying event would have caused the dependent to lose coverage under the Plan had the first qualifying event not occurred.

In order to be eligible for this second qualifying event extension, notice **must** be provided within 60 days after (a) the date of the second qualifying event, or (b) the date on which notice is provided by the Plan, by this SPD or by a general COBRA notice, of this obligation, whichever is later. Notice **must** be provided in writing to the Plan at the address in the front of this SPD. Such notice must include the name of the Plan, the Employee, the qualified beneficiaries, the second qualifying event and the date of the event.

VI. TERMINATION OF COBRA COVERAGE

A. COVERAGE UNDER COBRA WILL CEASE ON THE FIRST OF THE FOLLOWING DATES:

1. The date the Plan terminates;
2. The first day of the month for which the required monthly premium is not paid;
3. The date the qualified beneficiary becomes entitled to Medicare benefits following eligibility for COBRA continuation coverage;
4. The date the applicable period of COBRA continuation coverage is exhausted (24, 29 or 36 months); or
5. The date the qualified beneficiary becomes covered under another group health plan, except if the new group health plan has pre-existing condition limitations or exclusions that apply to the qualified beneficiary. The qualified beneficiary must demonstrate to the satisfaction of the Trustees that the new group health plan has such an exclusion and that it applies to him. If you have overlapping health coverage under this special rule, the Fund will coordinate coverage provided by your new group health plan based on the Fund's standard Coordination of Benefit rules. In no event, will the total payments for a particular service exceed 100% percent of the allowable expense under the Fund.
6. The date your former employer no longer provides coverage under any group health plan to any employee.
7. The date you are given a final determination by Social Security that you are **no longer** disabled, if you are covered in a COBRA extension as a result of

disability under Title II or XVI of the Social Security Act. The Fund Office must be notified of such determination no later than thirty (30) days after the date Social Security has deemed you no longer disabled.

VII. QUESTIONS

Questions concerning the Fund and/or COBRA continuation coverage should be addressed to the Fund Office at the address in the front of this SPD. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website.)

VIII. ADDRESS CHANGES

The Fund Office should be kept informed of any changes in the addresses of Participants and dependents in order to protect their rights.

IX. TRADE ACT OF 2002 AND COBRA

The Trade Act of 2002 created a special second COBRA election period, of up to 60 days, for individuals whose employment was displaced by import competition or shifts of production to other countries. In addition, the Act provided that the Treasury Department could advance Health Care Tax Credit (HCTC) directly to a group health plan for qualified workers. The Trade Act of 2002 was signed into law on August 6, 2002 and was effective as of November 4, 2002.

The Act provides for this second election period so that people who did not elect to take COBRA benefits during their initial election period could have another opportunity to elect extended benefits after becoming eligible for the HCTC (or state assistance for medical benefits).

The US Department of Labor (DOL) must certify that individuals are eligible. Employers may apply to the DOL for certification of a group of workers or an individual worker may apply for individual certification. The DOL determines if the worker's job was lost for trade-related reasons.

Health Care Tax Credit

The HCTC is a federal income tax credit of up to 65% of the premiums paid for qualified health insurance coverage, including COBRA coverage, by eligible "trade-displaced workers" who do not have other specified coverage. Workers are generally eligible for the HCTC if they are receiving trade assistance under the Trade Act of

1974 or getting a pension paid for by the Pension Benefit Guaranty Corporation (PBGC). "Qualified health coverage" means coverage of immediate family members for qualified coverage which excludes dental benefits.

The Trade Act of 2002 provides for the advance payment of HCTC directly to the qualified insurers for credit-qualified workers beginning on August 1, 2003. However, regardless of the payments from the Treasury Department, the worker would still have to pay at least 35% of the COBRA premium in keeping with the terms of the Plan.

Second Election Period

The second COBRA election period of up to 60 days begins the first day of the month in which a worker becomes eligible for federal trade adjustment assistance. However, the period may not extend beyond six months after the worker's original qualifying event.

An individual is eligible for this second election period if he (1) is receiving trade adjustment assistance (which requires government certification); (2) lost health coverage because he lost his job in a way that triggered his eligibility for trade adjustment assistance; and (3) failed to elect COBRA during the regular COBRA election period.

If the worker elects extended benefits during this second election period, coverage begins on the first day of the second election period. There is no retroactive coverage for the gap between the initial loss of coverage and the first day of the second election period. However, the second COBRA election period does not extend the original COBRA benefit period, which is still measured from the loss of coverage due to a qualifying event. Individuals seeking to elect COBRA coverage during this second election period must prove that they are certified to receive assistance.

Only a former worker may take advantage of the second election period, though he may do so on behalf of his eligible dependents. Dependents do not have an independent right to elect COBRA coverage in the second election period.

The Trade Act of 2002 does not create any new COBRA rights. Only workers who received COBRA notices after their qualifying event can elect COBRA during the second election period.

When the Plan receives the election form, the worker's coverage begins on the first day of the second election period. Please note that the workers' period of coverage runs from the date of his qualifying event, even though coverage is not retroactive to that date.

SECTION 15. CLAIM AND APPEAL PROCEDURES

Full descriptions of claims procedures are included in the benefits booklets provided by the Insurers. The following minimum procedure applies to medical **Post-Service Claims**, **Concurrent Claims Pre-Service Claims** and **Urgent Care Claims**, as well as claims for Short Term Disability, Life Insurance, Accidental Death & Dismemberment and Death Benefits.

A. WHEN CLAIMS MUST BE FILED

Claims must be filed within twelve (12) months from the date the charges were incurred. However, all claims for benefits should be submitted as soon as possible. No claim will be paid if first submitted more than twelve (12) months after the Participant received treatment or, in the case of Short-Term Disability benefits, more than twelve (12) months after the Participant lost income because he could not work.

In the event that a claim is denied for lack of information, the Participant will be informed of the additional information necessary to complete the claim. He must submit the requested information no later than twelve (12) months after the date that it was requested. No claim will be paid if the Insurer receives this information more than twelve (12) months after it is requested.

Claims for a Death Benefit are not subject to the twelve (12) month claim filing period. The beneficiary of a Death Benefit available under the Plan, or his representative, should send a certified copy of the death certificate to the Plan Office. In addition, if the beneficiary is the Spouse of the deceased, a copy of a marriage certificate must be submitted to the Plan. If the beneficiary is the parent of the deceased, a birth certificate must be submitted.

B. CLAIMS FILED BY PROVIDERS

An In-Network provider (please see the provider directories available from the Insurers) will file a claim with the Insurer when providing a Covered Service. The Participant shows his or her Identification Card to the provider and submits all necessary information to the provider for the claim to be submitted. A Participant has thirty (30) days from the date of service to provide all requested information to the provider.

An Out-Of-Network provider may bill the Insurer on a standard health care claim form.

C. CLAIMS FILED BY THE PARTICIPANT – PPO

1) The Insurer provides you with two levels of benefits known as in-network benefits and out-of-network benefits.
2) In-network benefits are available for covered benefits as described in the Insurer's benefits handbook which are received from the Insurer's network providers.

3) The Insurer's providers are providers that are under contract with the Insurer to provide services to Participants.
4) Out-of-network benefits are available for covered benefits as described in the Insurer's benefits handbook and received from non-network providers.
5) Some services require prior approval by the Insurer.

In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number

A Participant may file a claim with the Insurer when he or she receives a Covered Service from an Out-Of-Network provider. The provider may request payment of the entire charge at the time of the service and such charge is the responsibility of the Participant. In such a case, the Participant would file a claim for repayment with the insurer.

The Participant must fill out a claims form, attach the ***original*** itemized bill and mail to the Insurer's customer service office. Claims forms are available from the Insurers.

D. CLAIMS FILED BY THE PARTICIPANT – HMO

I. Conditions for Coverage of Services by a Disenrolled or Non-Plan Provider

Services received from a dis-enrolled or non-network provider as described in Insurer's benefits booklet, are only covered when the physician agrees to:

1. Accept reimbursement from the insurer at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Participant in an amount that would exceed the Participant cost sharing that could have been imposed if the provider had not been disenrolled;
2. Adhere to the quality assurance standards of the Plan and to provide us with necessary medical information related to the care provided; and
3. Adhere to the Insurer's policies and procedures, including procedures regarding referrals, obtaining prior approval and providing covered benefits pursuant to a treatment plan, if any, approved by the Insurer.

II. Clinical Review Criteria

The Insurer uses clinical review criteria to evaluate whether certain services or procedures are medically necessary for a Participant's care. Participants or their practitionersmay obtain a copy of the Insurers clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-800-241-0803**.

E. WHEN CLAIMS ARE CONSIDERED RECEIVED BY THE PLAN

1. **Post-Service Medical, Short Term Disability, Accidental Death & Dismemberment or Death Benefit Claims** are considered received on the first business day when the claim is received by U.S. mail or hand-delivered to the Insurer, or on the first business day when the claim is received electronically by the Insurer.

2. **Concurrent, Pre-Service and Urgent Care Claims** are generally requests for pre-certification of a treatment or hospital stay that is required by the Plan. A Concurrent, Pre-Service or Urgent Care claim is considered received when a telephone call is made to the Insurer, or the provider electronically contacts Insurer requesting pre-certification.

F. WHEN THE INSURER MUST RESPOND TO A CLAIM

1. **Post-Service Claims**

A Post-Service Claim is a claim submitted for payment after health services and treatment have been obtained and that is not a Pre-Service, Urgent Care or Concurrent Claim. If a Post-Service Claim for benefits is denied in whole or in part, the Participant will be informed in writing as soon as reasonably possible, but not more than 30 days after the receipt of the claim. Before the end of this 30-day period, the Insurer may notify a Participant in writing of the need for a 15-day extension for reasons beyond their control. The Participant will have 45 days from the date such information is requested to provide it, or the claim will be denied without further notice from the Insurer. The normal period for making a decision on the claim will be suspended from the date of the extension notice until either 45 days or until the date the Participant responds (whichever is earlier).

If a claim determination is not made within these time frames, the Participant can request an appeal in accordance with the procedures set forth in Section 15 (H), below.

2. **Urgent Care Claims**

An Urgent Care Claim is a claim for pre-certification of benefits for treatment that, if not received, (1) could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Any claim that a physician with knowledge of a Participant's medical condition determines is an Urgent Care Claim within this definition, will be treated as an Urgent Care Claim. Absent a determination by that physician, the Insurer will determine if a claim is an Urgent Care Claim.

If a Participant requests pre-certification of an Urgent Care Claim, the Insurer will respond to him and/or his provider with a determination by telephone as soon as possible taking into account the medical condition, but not later than 72 hours after receipt of the request. The determination will be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, or if it is improperly filed, the Insurer will notify the Participant and/or his provider as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim or of the proper procedures to be followed in filing a claim. The Participant and/or his provider must provide the specified information within 48 hours of receiving notice. If the information is not provided within that time, the claim will be denied. Regarding an improperly filed claim, if the claim is not re-filed properly, it will not constitute a claim.

Notice of the decision will be provided no later than 48 hours after the Insurer receives the specified information. Denials of Urgent Care Claims must include a description of the expedited appeal process.

3. Pre-Service Claims

A Pre-Service Claim is a claim for benefits for which the Plan and/or the Insurer requires approval of the benefit (in whole or in part) before medical care is obtained. For properly filed Pre-Service Claims, the Participant and/or his provider will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time to respond may be extended up to 15 days if necessary due to matters beyond the control of the Insurer. The Participant will be notified within the initial 15-day time period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Insurer needs additional information, the extension notice will specify the information needed. In that case, the Participant and/or his provider will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be deemed to be denied, without further notice from the Insurer. The normal timeframes for making a decision on the claim will be suspended for either 180 days or the date the Participant responds (whichever is earlier). The Insurer will then make a decision within 15 days of the date it receives the requested information and send out notice.

If the Participant or his provider improperly file a Pre-Service Claim, the Insurer will notify him as soon as possible, but not later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a claim. The Participant will only receive notice of an improperly filed Pre-Service Claim if the claim includes (i) the Participant's name, (ii) the specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

4. Concurrent Claims

A Concurrent Claim is a claim for additional treatment or hospital days that is being considered concurrently with the provision of treatment and results in a reduction, termination or extension of a benefit. It also means a claim that is reconsidered after an initial approval was made. (An example of this type of claim would be an inpatient hospital stay originally approved for five days that is reviewed at three days to determine if the full five days is appropriate).

The determination of a benefit with respect to a Concurrent Claim will be made by the Insurer as soon as possible, but in any event early enough to allow the Participant to have an appeal decided before the benefit is reduced or terminated.

Any request by a Participant to *extend* approved Urgent Care treatment will be acted upon by the Insurer within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve Urgent Care will be decided according to pre-service or post-service timeframes, whichever applies.

5. For Short Term Disability, Life Insurance, Accidental Death & Dismemberment, and Death Benefit Claims

The Insurer will make a decision on Short Term Disability, Life Insurance, Accidental Death & Dismemberment, or Death Benefit

claims and notify you of the decision within 45 days. If the Insurer requires an extension of time due to matters beyond its control, the Insurer will notify the Participant of the reason for the delay and when the decision will be made before the expiration of the 45-day period. A decision will be made within 30 days of the time the Insurer notifies the Participant of the delay. The period for making a decision may be delayed an additional 30 days, provided the Insurer notifies the Participant prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Insurer expects to render a decision.

The notice for the need of an extension will include:

- An explanation of the standards used for determining eligibility;
- The unresolved issues that prevent a decision on your claim; and
- The additional information necessary to resolve these issues.

If an extension is needed because the Insurer needs additional information, the extension notice will specify the information needed. In that case, the Participant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be deemed to be denied, without further notice from the Insurer. The normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier).

G. CLAIM DENIAL NOTICES

The notice of an adverse benefit determination will be sent to the provider and/or the Participant including, where applicable:

- the specific reason for the denial;
- the particular Plan provision upon which the denial is based;
- a description of any additional information that may be needed to complete the claim and why;
- if the denial was based on an internal Plan guideline or rule, a copy of the rule or guideline or a statement that it is available free of charge;
- if the denial is based on medical evidence, an explanation of the scientific or clinical judgment applied to the terms of the Plan; and
- an explanation of the Insurer's appeal procedures, including deadlines.

H. OVERPAYMENTS OR CLAIMS PAID DUE TO MISINFORMATION

If a Participant receives any benefits to which he is not eligible under the Plan, the Insurer has the right to recover the amount of the overpayment from any party, including the party who received such erroneous payment, the party who is responsible for such erroneous payment or the Participant. The Insurer may make such recovery by any means it deems advisable, including, but not limited

to, reducing future claim payments that the Participant or his Dependents would otherwise receive by the amount of the overpayment.

I. APPEAL OF AN ADVERSE BENEFIT DETERMINATION

1. How to Appeal a Denied Claim

If a claim is denied in whole or in part, or if you disagree with the decision made on a claim, you, or your duly authorized representative, may request a review of the denial of a claim by the Board of Trustees by submitting a written request for review to the Plan within 180 days after the receipt of written notice of an adverse benefit determination. You also have the right to (1) request to review all documents upon which the Insurer based its denial of your claim and (2) submit issues and comments in writing and any other material that supports your appeal.

If the Plan does not receive your written request for an appeal within 180 days of your receipt of the Insurer's denial, you will lose your right to have your claim appealed, including your right to sue the Plan. The Plan provides for only one appeal to the Board of Trustees for any denied claim.

The Board of Trustees is not bound by the previous adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that you may submit.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

2. Urgent, Pre-Service and Concurrent Claim Appeals

Such appeals generally should be made in writing to Plan. However, in certain circumstances such as urgent claim appeals in which medical conditions exist that require an expedited review process, appeals may be made via telephone to Plan Office at the telephone number on the front page of this SPD twenty-four hours a day, seven days a week. All other calls must be made during normal business hours, which are 9:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays.

A sub-committee consisting of several appointed Trustees will review Urgent, Pre-Service and Concurrent Claim appeals.

3. Post-Service, Short Term Disability, Life Insurance, Accidental Death & Dismemberment, and Death Benefit Claim Appeals

Post-service, short term disability, life insurance, accidental death & dismemberment, and death benefit claim appeals must be made in

writing to the Board of Trustees in care of the Fund Office and must be received within 180 days after you receive notice of a denied claim.

4. Information to which You are Entitled

You have the right to review documents relevant to your claim. A document, record or other information is relevant if:

- it was relied upon by the Plan in making the decision;
- it was submitted, considered or generated (regardless of whether it was relied upon) in making the decision;
- it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or
- it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, who gave advice to the Board of Trustees or its sub-committee on your claim, without regard to whether their advice was relied upon in deciding your claim.

5. Timing of Notice of Decision of Appeal

a. Pre-Service or Concurrent Claim Appeals

You will be sent a notice of decision of the appeal within 30 days of receipt of the appeal by the Board of Trustees.

b. Urgent Care Claim Appeals

You will be notified of a decision on your appeal, either orally or in writing (or both) within 72 hours of receipt of the appeal by the Board of Trustees or its sub-committee.

c. Post-Service, Short Term Disability, Life Insurance, Accidental Death & Dismemberment, or Death Benefit Claim Appeals

A decision will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for an appeal. However, if your request for an appeal is received within 30 days of the next regularly scheduled meeting, your request for an appeal will be considered at the second regularly scheduled meeting following receipt of your request.

In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on your appeal has been reached, you will be given written notice of the decision as soon as possible, but no later than 5 days after the decision has been reached.

6. Notice of Decision on Appeal

The decision on an appeal will be given to you in writing. The notice of a denial of an appeal will state:

- the specific reason for the denial;
- the particular Plan provision upon which the denial is based;
- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- if the denial was based on an internal Plan guideline or rule, a copy of the rule or guideline or a statement that it is available free of charge;
- if the denial is based on medical evidence, an explanation of the scientific or clinical judgment applied to the terms of the Plan; and
- a statement of your rights under Federal law.

SECTION 16. WHEN THIRD PARTIES MAY BE LIABLE

If the Insurer provides any benefits to a Participant related to an illness, injury or loss for a which a third party may be liable, the Insurer may have the right to be reimbursed for their expenses from the proceeds of any recoveries, settlements, awards or judgments in damages related to such illness, injury or loss that a Participant receives or anybody receives on his behalf from a third party or insurance carrier to the full extent of the total benefits paid on the Participant's behalf. The Insurer will hold a first priority lien on such recoveries, settlements, awards or judgments. This includes but is not limited to any recovery under a Participant's uninsured or underinsured motorist coverage or pursuant to a Participant's homeowner's policy.

A. THE INSURERS' REIMBURSEMENT RIGHTS

The Insurer's lien must be satisfied as a first priority ahead of the Participant, the Participant's attorneys, or any other person from the proceeds of such recovery, settlement, award or judgment, if the Insurer has the right to be reimbursed.

If the Insurer has the right to be reimbursed, the Insurer's lien must be reimbursed before any such proceeds are disbursed, regardless of whether the Participant receives such proceeds, or they are received by a person acting on the Participant's behalf. By accepting benefits in such circumstances, the Participant agrees on behalf of himself and his attorney or any person acting on the Participant's behalf that any person who receives such assets shall hold them in constructive trust for the Insurer until the Insurer is reimbursed.

If the Insurer has the right to be reimbursed, the Insurer has the right to be reimbursed to the full extent of its expenses without any reduction for attorneys' fees or any other costs or expenses.

If the Insurer has the right to be reimbursed, the Insurer has the right to be fully reimbursed whether or not the Participant is fully compensated for his damages or medical expenses.

B. THE PARTICIPANT'S OBLIGATIONS

The Participant and his attorney, if he has retained one, must complete any forms supplied by the Insurer, such as an agreement to reimburse the Insurer and/or an acknowledgement of the Insurer's lien. The Participant and his attorney must supply all information that the Insurer may reasonably require.

The Participant is required to notify the Insurer of any claims for damages or other recovery against a third party or an insurance carrier. The Participant is required to immediately notify the Insurer if he receives any recoveries, settlements, awards or judgments from any source.

A Participant in this Plan, whether or not he fulfills the Insurers requirements, if he accepts benefits in circumstances in which the Insurer has the right to be reimbursed, he is bound by the obligation to reimburse the Insurer and is subject to the Insurer's right to be reimbursed, as outlined in this section, as are his attorneys, agents, assigns or heirs and executors. A Participant in this Plan, whether or not he fulfills the Insurers requirements, if he accepts benefits in circumstances in which the Insurer has the right to be reimbursed, acknowledges that any legal expenses are his own responsibility, and that it is his obligation to notify his attorney of these provisions and assignment.

C. SUBROGATION RIGHTS

If the Insurer incurs any expenses related to such an illness, injury or loss, (or pays them in error) the Insurer will have the right to subrogate to any rights a Participant in the Plan may have against a third party or insurance carrier to the extent of its expenses. In other words, the Insurer may exercise any right you have against such third party or insurance carrier. The Insurer may intervene in or subrogate to the Participant's interest in any related claim or cause of action to secure reimbursement of its expenses.

D. ENFORCEMENT PROCEDURES AND REMEDIES

If the Insurer has a right to be reimbursed and the Participant and/or his attorney(s) fail to reimburse the Insurer, the Insurer may bring suit under ERISA to recover its expenses. If the Insurer files such legal action, the Participant could be responsible for the costs and expenses necessary to secure the reimbursement, including attorneys' fees, and interest.

In addition to any other remedy that may be available under applicable law, the Insurer may exercise the following remedies if the Participant fails to comply with his obligations as stated in this section:

- If the Participant and/or his attorney(s) fail to cooperate with the Insurer, in any way, such as refusing to provide updated information regarding his third-party claim, the Insurer may assume that he does not intend to honor the Insurer's lien and may decline to pay any benefits to which the Participant and his Dependents would otherwise be eligible until the matter is resolved; or
- The Insurer may deduct any non-reimbursed expenses from claims otherwise payable to the Participant and/or his Dependents until the Insurer recovers all of its expenses.

E. WORK-RELATED INJURIES OR ILLNESSES

The Plan does not cover any bills directly or indirectly related to a work-related injury or illness unless the related claim is denied by Workers' Compensation. Any bills related to a work-related injury or illness must be submitted through the Employer for Workers' Compensation coverage. However, the Plan and the Insurer may, in their sole discretion, advance such expenses if a copy of the notice that the Employer is contesting liability is provided to the Fund Office and the Insurer.

In addition, the Participant and his attorney, if he has one, must complete any forms supplied by the Insurer, such as an agreement to reimburse the Insurer and an acknowledgement of the Insurer's lien. The Participant and his attorney must supply all information that the Insurer may reasonably require.

The Plan does not cover claims, if the Employer's Workers' Comp insurer did not cover them because the Participant failed to comply with the provisions of that insurance.

If the Workers' Comp. Commissioner determines that the claims paid by the Insurer are the responsibility of the Participant's Employer, the Insurer will seek reimbursement of such expenses from the providers. However, if the providers do not fully reimburse the Insurer, the Insurer may use any method available to secure reimbursement, including deducting any non-reimbursed expenses from claims otherwise payable to the Participant and/or his Dependents until the Insurers is fully reimbursed.

F. COORDINATION WITH "PERSONAL INJURY PROTECTION"

"Personal Injury Protection" ("PIP") (also known as "Med Pay" coverage) is a provision of automobile insurance that, in the event you are in an accident, covers some of your medical expenses, regardless of who was at fault in the

accident. Massachusetts requires that every driver carry PIP. The Plan will only provide coverage after your PIP threshold has been met.

If you live in a state that requires PIP coverage, such as Massachusetts (also New York, New Jersey and Pennsylvania, in the Northeast United States) the Plan will only cover expenses after the required PIP minimum coverage has been exhausted, even if the Participant does not carry the required PIP coverage. Therefore, the Plan must first obtain either (a) proof that the driver has PIP coverage and that it has been exhausted or (b) proof of payment of medical expenses related to the accident up to the minimum coverage threshold, before any benefits are paid by the Plan.

The Trustees may establish rules and regulations to govern procedures hereunder.

SECTION 17. SCHOLARSHIP AWARDS

The Welfare Plan, through the Massachusetts AFL-CIO Scholarship exam awards three Scholarships annually to the son or daughter of a Local 12 Member who has taken the Massachusetts AFL-CIO Scholarship examination. The students' AFL-CIO exam score will determine scholarship awards.

REQUIREMENTS

ALL STUDENTS MUST:

a) Be a senior in high school and plan to attend some form of higher education in the fall.

b) Sign up with the exam coordinator at their high school pursuant to the rules put forth by the AFL-CIO Scholarship Committee in order to have an exam ordered for them.

c) Complete the scholarship application and download the study guide from the Massachusetts AFL-CIO website at: http://www.massaflcio.org/scholarship-program

d) Take the Labor History Exam on the date the Massachusetts AFL-CIO designates.

e) Applications can be mailed to Massachusetts AFL-CIO, 389 Main Street, Suite 101, Malden, MA. 02148 Attention Scholarships or Faxed to (781) 324-8225.

SECTION 18. COORDINATION OF BENEFITS

There are many instances where two group health plans or a group health plan and a homeowner's, automobile, general or other liability insurance policy may be available or may pay health benefits for you. For that reason, the Plan has rules regarding which plan applies its plan of benefits first, which may affect the benefits you receive from this Plan. These rules are called Coordination of Benefits.

The plan that pays first is called the "Primary Payor." The plan that pays second is called the "Secondary Payor." In the event that there is a plan that pays third, that plan is called the "Tertiary Payor." The Primary Payor will cover a bill to the full extent of the allowable expenses under that plan. ("Allowable expense" means the amount payable under the terms of the plan of benefits for a Covered Service or treatment. "Allowable expense" under the Plan may also include Short Term Disability benefits). After the Primary Payor pays the allowable expense under that plan, if any, the Secondary Payor will pay any balance up to the allowable expense in that plan.

If you are also covered for health benefits under any other group plan or homeowner's, automobile, general or other liability insurance policy, the total payment you receive from all sources combined may not exceed 100% of the Plan's "allowable expense." If an employer-sponsored Health Maintenance Organization is determined to be the Primary Payor, the Plan will only pay the required co-payments. If you fail to comply with the rules of this or any other applicable plan, these Coordination of Benefit rules will not be applied.

The Coordination of Benefits rules do not apply if the other health coverage is an individual health insurance policy.

The Fund may require written documentation regarding the existence of or changes in your other insurance coverage.

You must report any of the following coverage to the Fund Office and any changes to this coverage:

- group health benefits provided by any other employer or organization;
- health care benefits or short-term disability benefits provided under homeowner's, automobile, general or other liability insurance policy;
- blanket or franchise insurance, or
- governmental programs including Medicare or Medicaid, or coverage required or provided by law excluding only coverage which is not allowed by law to be coordinated.

A. WHICH PLAN PAYS FIRST

1. A plan that does not have a Coordination of Benefits provision is the Primary

Payor.

2. If a Participant is covered by two plans based on his employment, the plan that has continuously covered him longer is the Primary Payor; except that a plan that covers him as an active Employee pays before a plan that covers him as a laid-off Employee or as a retiree.

3. The plan that covers a Dependent based on the Dependent's employment, even if the Dependent is retired or laid off, is the Primary Payor. For example, if the Dependent is covered under this Plan because her spouse is a Participant employed in Covered Employment and she also has coverage through her former employer as a retiree, the coverage through her former employer is the Primary Payor.

4. In the case of a homeowner's, automobile, blanket or franchise, general, or other liability insurance policy, the Plan is secondary.

If the above rules do not determine which plan's benefits are payable first, the plan that has covered the claimant for the longer period of time will pay benefits first regardless of changes in benefit plan provider or administrator.

B. WHICH PLAN PAYS FIRST FOR DEPENDENT CHILDREN

The rules below determine which plan's benefits are payable first if a Dependent Child is covered under two or more plans:

1. If a Child is covered under both parents' plans, this Plan uses the "Birthday Rule." This means that the plan that covers the parent whose date of birth occurs earlier in the calendar year, pays first. For example, if a Child's father's birthday is in January and the mother's birthday is in February, the father's plan pays first. If the parents' birthdays are on the same date, the plan that has continuously covered either parent longest pays first. If the other plan does not use the Birthday Rule, the Birthday Rule will still apply.
2. If a Qualified Medical Child Support Order (QMCSO), divorce decree, court document or another legal document provides that the Participant shall be responsible for the Child's coverage, this Plan will be Primary. If the document provides that both parents shall share equally in the responsibility for providing child coverage, the Birthday Rule applies. If there is no QMCSO or other document requiring that the Participant provide coverage for the Child, this Plan will pay benefits only if the Child qualifies as a Dependent.
3. If your Child qualifies as a Dependent and a QMCSO or other document provides that the Child's other parent is required to provide coverage for the Child, this Plan will be the Secondary Payor. If the order provides that both parents shall share equally in the responsibility for providing care, the Birthday Rule applies. If there is no QMCSO requiring coverage, or if there is evidence satisfactory to the Trustees

that the other parent of the Child is not complying with such order, this Plan will pay benefits for a Dependent Child as the Primary Payor.

C. FAILURE TO COMPLY WITH PROVISIONS OF THE PRIMARY PLAN

If the Primary Payor does not pay certain expenses because a Participant has failed to comply with provisions of that plan, those expenses will not be eligible for reimbursement under the terms of this Plan.

D. COORDINATION WITH NO-FAULT INSURANCE

In a state where no-fault automobile insurance is required, no-fault is the Primary Payor. When any insurance coverage, including no-fault, is mandated and a Participant does not have it, the Fund will apply the Coordination of Benefits rules as if he did.

E. COORDINATION OF BENEFITS WITH MEDICARE

This Plan will continue to be primary for Participants and their Dependents (pursuant to these Coordination of Benefit rules) even after the Participant is eligible for insurance benefits under Title XVIII of the Social Security Act of 1965 (Medicare). However, if the Participant is receiving benefits based on his active employment, this Plan will be secondary to Medicare.

If a Participant is entitled to Medicare Benefits solely because he or she is in the first 30 months of end stage renal disease (ESRD) treatment, this Plan will be primary for all medical benefits, provided the Participant is covered under this Plan based on active employment or as a Dependent of an active employee in the absence of any other coverage. The Plan becomes secondary for all medical benefits after the 30-month period is completed.

You must apply to the Social Security Administration for ESRD coverage as soon as possible.

SECTION 19. DESIGNATING A BENEFICIARY

The Participant May Designate a Beneficiary

1. A Participant may designate a person or persons as Beneficiary for purposes of receiving an Eligible Death Benefit. The Participant's Beneficiary or Beneficiaries will receive any Eligible Death Benefit payable upon the Participant's death. A Participant may change a Beneficiary designation by completing and signing a beneficiary designation form. These forms are available at the Fund Office. This form must be on file at the Fund Office in order to be valid.

If a Participant is not survived by a designated Beneficiary or if the Participant's Beneficiary cannot be located, an Eligible Death Benefit will be paid in the order listed below:

- To the Participant's surviving spouse;

- To the Participant's surviving children, equally;
- To the Participant's surviving parents, equally;
- To the Participant's surviving sisters or brothers, equally; or
- To the Participant's estate.

If no executor or administrator of the Participant's estate is appointed and qualified within 180 days of notice of his or her death, the Trustees in their discretion may determine a recipient of the Eligible Death Benefit, for example among any person or persons found by the Trustees to be equitably entitled by reason of having paid or incurred expenses on account of the funeral or last illness of the Participant.

2. The Participant's Beneficiary May Disclaim the Lump Sum Death Benefit

After the Participant's death, a Beneficiary may refuse to accept (*i.e.*, disclaim) the Eligible Death Benefit. If this happens, the portion of the Eligible Death Benefit payable to such Beneficiary will pass to the next Beneficiary in order of succession. The Beneficiary disclaiming the benefit does not get to name the Beneficiary to receive the disclaimed benefit. Such disclaimer must comply with the requirements of section 2518 of the Internal Revenue Code of 1986, as amended, along with the following requirements:

- The refusal or disclaimer must be in writing.
- The refusal or disclaimer must be received by the Fund Office within 9 months of the later of (a) the date of death of the Participant, or (b) the day on which such person attains age 21.
- The Beneficiary disclaiming the benefit has not accepted the interest or any of its benefits.
- There are no encumbrances on the Beneficiary's interest before making the disclaimer.
- The Beneficiary disclaiming the benefit is not insolvent at the time of the disclaimer.
- The Beneficiary disclaiming the benefit has not waived his ability to do so, due to appointment of a guardian or conservator of the Beneficiary.

If you are a Beneficiary that satisfies the above requirements and wish to disclaim an interest, you may obtain the necessary forms from the Fund Office.

3. Payments to Minors

If the Beneficiary is a minor, any benefits payable to such Beneficiary shall be paid only to such minor's legally appointed guardian. The legal guardian will be required to provide such evidence of legal guardianship as the Trustees may require, which may include a certified copy of the decree under which such guardian was appointed and a certification by such guardian that the decree has not been modified or revoked and has not lapsed for any reason, as well as such other information or certifications as the Trustees may reasonably require.

SECTION 20. OPERATION OF THE PLAN

A. AMENDMENT AND TERMINATION

The Plan may be amended, canceled or discontinued at any time by the Trustees, but no amendment or termination of the Plan will adversely affect a claim incurred prior to the termination or amendment.

B. CERTIFICATES OF CREDITABLE COVERAGE

If your health coverage under the Plan stops, you and your covered Dependents will receive a certificate that shows your period of health coverage under the Plan. This is known as a Certificate of Creditable Coverage. You may need to furnish this certificate if you become eligible under another group health plan which excludes coverage for certain medical conditions that you have before you enroll (known as pre-existing condition exclusions). You may also need the certificate in the event you want to buy, for yourself or your family, an individual health insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your covered Dependents may also request a Certificate of Creditable Coverage within 24 months of losing health coverage under the Plan.

C. PRIVACY PRACTICES

Please carefully review the descriptions of benefits provided by the Insurer(s) for descriptions of how medical information about you may be used and disclosed, how you can get access to this information and your rights under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

If you believe that your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the Plan Office, identified at the beginning of this SPD.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, by writing to him or her at the following address: The Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

D. MEDICARE PART D

Please read this section carefully and keep this SPD where you can find it. This section has information about your current prescription drug coverage with the Plan and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. Starting January 1, 2006, new Medicare prescription drug coverage became available to everyone with Medicare.

2. The Plan has determined that the prescription drug coverage it offers, on average for all plan participants, is expected to pay out as much as the standard Medicare prescription drug coverage will pay.

3. Read this section carefully; it explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll.

   You may have heard about Medicare's new prescription drug coverage and wondered how it would affect you. As noted above, the Plan has determined that your prescription drug coverage is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

   As of January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium. Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

   People with Medicare can enroll in a Medicare prescription drug plan during the annual enrollment periods between November 15 through December 31. However, because you have existing prescription drug coverage that, on average, is as at least as good as Medicare's coverage, you can choose to continue the Plan's coverage and join a Medicare prescription drug plan later without paying a late enrollment penalty, provided you enroll in a timely manner.

   If you do decide to enroll in a Medicare prescription drug plan now and drop your prescription drug coverage under the Plan, please be aware that you may not be able to get coverage under the Plan back. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Please see the sections of the Plan regarding "PRESCRIPTION DRUG BENEFIT" for information about the prescription drug benefits offered by the Plan. The Plan pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

   You should also know that if you drop or lose your coverage with the Plan and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you

go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium for Medicare's coverage will go up at least 1% per month for every month that you did not have such coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next November to enroll.

For more information about this notice or your current prescription drug coverage, contact the Plan Office. You will receive this notice annually. You may also request a copy by contacting the Plan Office.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You 2007" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & Your handbook for their telephone number)
- Call 1 800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486 2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this booklet where you can find it. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

E. FAMILY AND MEDICAL LEAVE ACT ("FMLA")

Under this federal law, you may have the right to take up to 12 weeks of unpaid leave from your employment in a 12-month period for the birth or adoption of a child; to care for a spouse, child, or parent with a serious health condition; and when you are unable to work because of a serious health condition. If you are out of work because of a qualified Family and Medical Leave Act leave of absence, you may choose to continue your health coverage during your leave of absence, or you may choose to suspend coverage during your leave. If you continue coverage during your leave of absence you and your eligible

Dependents will be covered under this Plan while you are absent from work. The coverage will continue as if you were actively working until the earlier of the expiration of your FMLA leave or the date you give notice to your employer that you will not return from your leave.

You are required to pay the employee's portion of the cost of medical coverage, if any. However, if you choose to suspend coverage during your absence, you and your eligible Dependents will become covered immediately upon your return to work without being required to give evidence of prior creditable coverage. Also, you and such Dependents will be excluded from any preexisting requirements under the Plan.

If you decide to take a FMLA leave of absence, contact the Plan Office for further information and election forms.

SECTION 21. STATEMENT OF RIGHTS UNDER ERISA

As participants in the Plan, Participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

A. INFORMATION ABOUT BENEFITS

Participants may examine, without charge, at the Plan Office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Participants may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan may make reasonable charge for the copies.

Participants may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the summary annual report.

B. CONTINUATION OF GROUP HEALTH PLAN COVERAGE

Covered Participants are allowed to continue health care coverage for themselves, their spouses and/or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Participants may have to pay for such coverage. COBRA rights are outlined in Section 14.

C. REDUCTION OR ELIMINATION OF EXCLUSIONARY PERIODS OF COVERAGE FOR PRE-EXISTING CONDITIONS

If a Participant has Creditable Coverage from another plan, he or she is entitled to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the Plan, if such exclusions exist in the plan of benefits. Participants should be provided with a certificate of Creditable Coverage, free of charge, from their health plan or insurer (1) when they lose coverage under the terms of the plan, (2) when they become entitled to elect COBRA continuation coverage, (3) when their COBRA continuation coverage ceases, (4) if the Participant requests such certificate before losing coverage, or (5) up to twenty-four (24) months after losing coverage. Without evidence of Creditable Coverage, Participants may be subject to a pre-existing condition exclusion for the first twelve (12) months after their date of hire by a Contributing Employer in a class of employees eligible to participate in the Plan if such exclusions exist in the plan of benefits.

D. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan, called "fiduciaries" of the Plan. They have a duty to operate the Plan prudently and in the interest of the Participants. No one, including employers, the Union, or any other person may fire a Participant from his or her job or otherwise discriminate against a Participant in any way in order to prevent the Participant from obtaining a health benefit or exercising his or her rights under ERISA.

E. ENFORCEMENT OF THESE RIGHTS

If a claim for health benefits is denied or ignored in whole or in part, the Participant must receive a written explanation of the reason for the denial. The Participant has the right to have the denial reviewed and reconsidered within certain timetables. The Participant has the right to know why his or her claim was denied and to obtain copies of documents relating to the decision without charge.

Under ERISA, there are steps that can be taken to enforce the above rights. For instance, if a Participant requests a copy of Plan documents or the latest summary annual report from the Plan and does not receive them within thirty (30) days, he or she may file suit in Federal court. In such a case, the court may require the Plan to provide the materials and pay the Participant up to $110.^{00}$ per day for each day the Plan failed to provide the requested materials, unless the materials were not sent for reasons beyond the control of the Plan.

If a Participant has a claim for benefits that is denied or ignored, in whole or in part, he or she may file a suit in Federal court.

In addition, if a Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, he or she may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting these rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in Federal court.

The court will decide who should pay court costs and legal fees. If a Participant's suit is successful, the court may order the person being sued to pay these. If the Participant loses, the court may order him or her to pay these fees, especially if the court finds the claim to have been frivolous.

F. ASSISTANCE WITH YOUR QUESTIONS

All questions about the Plan should be directed to the Fund Office.

All questions about this statement or about a Participant's rights under ERISA—or if assistance is needed in getting documents from the Plan—Participants should contact the nearest Office of the Pension & Welfare Benefits Administration at the U.S. Department of Labor, listed in your telephone directory. The nearest location can also be found by contacting:

Division of Technical Assistance and Inquiries
Pension & Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210.

Certain publications about your rights and responsibilities under ERISA can be obtained by calling the "Publication Hotline" of the Pension & Welfare Benefits Administration.

SECTION 22. DEFINITIONS

Some of the terms used in this booklet have special meanings under the Plan, as set forth below. These terms will always begin with capital letters. Definitions are also provided in the description of benefits booklet available from the Insurer.

1. ACUPUNCTURE

A Treatment used for pain therapy applied by a licensed Acupuncturist.

2. ALLOWABLE CHARGE

The Allowable Charge is the charge that is used to calculate the payment of benefits. The Allowable Charge depends on the type of health care provider that furnishes the benefit. Definitions are also provided in the description of benefits booklet available from the Insurer(s).

3. CHILD

Children or Child means:

a. A Participant's natural children;
b. A child for whom the Participant is a foster parent;
c. A Participant's adopted Children;
d. Children who have been placed in the Participant's home and for whom adoption is pending; and
e. A Child for whom the Participant is appointed legal guardian who lives with the Participant

4. CO-INSURANCE

Co-Insurance is the portion of the cost (most often described as a percentage) of certain Covered Services that Participants must pay. Definitions are also provided in the description of benefits booklet available from the Insurer(s). Co-Insurance is a portion of the Provider's actual charge (unless otherwise required by law).

5. CO-PAYMENT

A Co-Payment is a fixed dollar amount that a Participant must pay for certain Covered Services before the Plan will pay the balance of the Allowable Charge. (When the provider's actual charge is less than the Co-Payment, the Participant only pays the provider's actual charge.) A Provider will usually collect the Co-Payment at the time he or she furnished the Covered Service.

6. COVERED EMPLOYMENT

Covered Employment is employment for which contributions are required to be made to the Fund pursuant to a collective bargaining agreement between the Plumbers' Union, Local No. 12 and the Plumbers Heating Cooling Contractors of Greater Boston or another Employer. Covered Employment shall also mean full-time employment, as defined herein, with the Fund Office, union office or a contributing Employer that has executed a Participation Agreement with the Trustees.

7. COVERED SERVICES

Covered Services are health care services that are covered by the Plan as described in this SPD and the description of benefits booklets provided by the Insurer(s).

8. CUSTODIAL CARE

Shall mean any service or supply, including room and board, which: (1) is furnished mainly to help a covered person meet his/her daily needs; and (2) can be furnished by someone who has no professional health care training or skills. **Custodial Care is excluded from coverage even if a covered person is confined to a hospital or other recognized facility.**

9. DEDUCTIBLE

The Deductible is the amount a Participant must pay before benefits for Covered Services are provided. Definitions are also provided in the description of benefits booklet(s) available from the Insurer(s). The amount of charges that are put toward the Deductible are based on the provider's actual charge or the Allowed Charge, whichever is less (unless otherwise required by law).

There are amounts for which a Participant is responsible that do not count toward the Deductible such as any Co-Payment or any amount paid because the Participant did not follow the Utilization Review program.

10. DEDUCTIBLE REIMBURSEMENT

The amount of reimbursement of the Insurer's Deductible charges allowed for refund to a Participant within a Plan Year. Spouses and Dependents are not eligible for Deductible reimbursement unless enrolled in the Insurer's coverage under their own policy as an individual Subscriber. This benefit does not apply to Medicare Supplemental Plan Participant's or Retiree Special Benefit Participant's.

11. DEPENDENT

A. The Spouse of an Employee or Retiree. For the purposes of the Plan, a widower or widow of an Employee or Retiree, may continue to be covered under the Plan, subject to any additional contribution required by the Trustees, only if he or she was covered in the Plan at the time the Employee or Retiree died. For the purposes of the Plan, a person who has been granted a divorce judgment or an order of separate support from an Employee or Retiree, who at the time such judgment or order was granted was a Participant, shall remain a Participant (unless such judgment provides to the contrary), until the earliest of:

1. the remarriage of such person;
2. the remarriage of the Employee or Retiree provided, however, that if an applicable judgment so provides, the former spouse may continue to be covered under the Plan, subject to any additional contribution if required by the Trustees;

3. the date the Employee or Retiree ceases to be a Participant; or
4. the termination date provided by such judgment.

B. An Employee's or Retiree's Child between the ages of birth and 26 years of age.

C. An Employee's or Retiree's Child who is unmarried, 26 years old or older and who is financially dependent on the Participant for his livelihood and who is incapable of self-sustaining employment because of disability who was covered by the Plan as of their 26th birthday.

D. Persons on active duty in any military service of any country are excluded as Dependents.

12. EMERGENCY MEDICAL CARE

Emergency Medical Care is medical, surgical or psychiatric care that is needed immediately due to the sudden onset of a condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses average knowledge of health and medicine to seriously jeopardize the health of the Participant or another (including a fetus), including the serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Some examples of conditions that require Emergency Medical Care are suspected heart attacks, strokes, poisoning, and loss of consciousness or convulsions. Definitions are also provided in the description of benefits booklet available from the Insurer.

13. ELIGIBLE DEATH BENEFIT

Death Benefits payable according to **Section 9 (C)(1)(2).**

14. EMPLOYEE

An Employee is any person employed in Covered Employment, employees of the Fund Office, employees of the Local and employees of signatory contractors who have executed a Participation Agreement with the Trustees requiring contributions to be made to the Fund in the same manner as a participating Employer.

15. EMPLOYER

An Employer is any contractor signatory to the Plumbers' Union, Local No. 12 collective bargaining agreement with the Plumbing Heating Cooling Contractors of Greater Boston that contributes to the Fund pursuant to such collective bargaining agreement or is party to any other agreement requiring such contributions to the Fund and who makes such contributions pursuant to such other agreement.

16. ERISA

The Employee Retirement Income Security Act of 1974, as amended from time to time.

17. FUND OFFICE OR PLAN OFFICE

The Fund Office for the Plumbers' Union, Local No. 12 Welfare Fund.

18. HEARING AID

An electronic device designed to amplify sound for the purpose of making speech more intelligible.

19. INSURERS

The Companies with which the Trustees have contracted to provide the services outlined herein.

20. LOCAL

The Plumbers' Union, Local No. 12.

21. MEDICALLY NECESSARY or MEDICAL NECESSITY

To be Medically Necessary, a service must be:

1. consistent with the diagnosis and treatment of the condition;
2. in accordance with standards of good medical practice; and
3. performed not solely for the convenience of the Participant, his family or the provider.

22. MEDICARE

Title XVIII (Health Insurance for the Aged) of the U.S. Social Security Act as amended by the Social Security Amendment of 1965 or as later amended.

23. PARTICIPANT

A Participant is an Employee, Retired Participant or Dependent who has the right to receive benefits under the Plan.

24. PARTICIPATION AGREEMENT

A Participation Agreement is a written agreement between the Trustees and an Employer requiring contributions on behalf of non-collectively bargained Employees of the Employer and the provision of benefits to such non-bargained Employees.

25. PLAN SPONSOR

The Board of Trustees is the Plan Sponsor, pursuant to ERISA.

26. QUALIFIED MEDICAL CHILD SUPPORT ORDER or QMCSO

A Qualified Medical Child Support Order or QMCSO is a court order or other document recognized under ERISA creating the right to receive benefits under the Plan as a Dependent for any Child of a Participant or Retiree who is a named in such an order.

27. RETIRED PARTICIPANT or RETIREE

Any Participant who is receiving a pension through the Plumbers' Union, Local 12 Pension Fund and was an active eligible participant in the Fund either maintained by hours worked or self-payment may continue health coverage pursuant to the eligibility requirements described in Part 1 H(1)(2)(3).

28. SCHOLARSHIP

The term Scholarship shall mean the three $1,500 John J. Cotter Memorial Scholarships. Awarded by the Trustees pursuant to SECTION 17.

29. SPOUSE

The term "Spouse" shall mean lawful spouse as recognized by the Commonwealth of Massachusetts, not including common law spouse, ex-spouse (except as required by law) and it does not include domestic partner.

30. SUBSCRIBER

The eligible Participant enrolled under the Insurer's coverage by virtue of Plan Eligibility Rules. The subscriber may be a family or an individual. The Subscriber is the Eligible Participant under which an Insurer Subscriber number is assigned. Eligible spouses and dependents are identified by the Insurer under the Insurer's assigned Subscriber number.

31. TRUSTEES

The Board of Trustees of the Plumbers' Union, Local No. 12 Welfare Fund.

32. TUINA THERAPY

A treatment used for Pain Management applied by a licensed massage therapist.

PLUMBERS' UNION LOCAL NO. 12 WELFARE FUND

Medicare Supplemental Health Plan

1230 – 1236 Massachusetts Avenue
Boston, Massachusetts 02125
Tel: (617) 288-5400 Toll Free: 1-800-452-9995
Fax (617) 288 - 3871

BOARD OF TRUSTEES

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FUND COUNSEL

Robert M. Cheverie & Associates P.C.
Commerce Center One
333 East River Drive, Suite 101
East Hartford, Connecticut 06108
(860) 290-9610

PARTICIPATING EMPLOYERS

Greater Boston Plumbing Contractors Association, Inc
(Formally the PHCC of Greater Boston, Inc.)

PARTICIPATING LOCAL UNION

Plumbing and Gasfitters Local No. 12 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada

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INTRODUCTION

The following questions and answers will introduce you to the Plumbers' Union Local 12 Welfare Fund Retiree Medicare Supplemental Plan. A fuller explanation of the Plan follows this Introduction. You should review the full Supplemental Plan so that you understand your rights and obligations.

WHAT IS THE RETIREE MEDICARE SUPPLEMENTAL PLAN?

This Plan is designed to supplement Medicare's Part A and Part B coverage. If Medicare approves of a bill or charge, Medicare will only pay a portion of the approved amount of the total bill. For example, if you have surgery performed, Medicare Part B may pay only 80% of its approved amount after an annual deductible. In this case, the Supplemental Plan would supplement Medicare Part B by paying the annual deductible and the amount, which Medicare determines, is your copayment amount or patient responsibility. This Plan includes Medicare Part D prescription Coverage.

DO I HAVE TO BE ENROLLED IN MEDICARE PARTS A AND B TO PARTICIPATE?

Yes, since this Plan supplements Medicare Parts A and B, if you are not enrolled in Medicare Parts A and B, no supplemental coverage is provided, and you are not eligible to enroll in this Plan.

HOW DO I BECOME ELIGIBLE?

You must have been eligible under the Plumbers' Union Local No. 12 Welfare Fund Class A coverage for a 10 consecutive year period, accumulated sufficient hours and satisfied other rules. Refer to the Eligibility Rules section of the Welfare Plan.

DO I HAVE TO PAY A PREMIUM FOR COVERAGE?

Yes. The premium amount is established by the Trustees at their sole discretion and may be changed at any time and from time to time. A $2,484 per covered person annual premium has been initially established, payable monthly in advance. If your Medicare enrolled spouse is also eligible, your spouse must pay this premium as well for coverage. Given inflation, and especially that prescription drug costs have been rising at many times the rate of inflation, if you enroll in this Plan, you should expect frequent increases to the annual premium.

WHAT HAPPENS IF I FAIL TO TIMELY PAY THE PREMIUM?

Your participation and coverage will automatically terminate without further notice to you and you will not be eligible to enroll in the Supplemental Plan in the future.

ELIGIBILITY RULES

A. ELIGIBILITY RULES FOR MEMBERS

In order to be able to enroll in the Retiree Medicare Supplemental Plan, **you must be age 65 or older, retired and eligible for and enrolled in Medicare Parts A and B.** You are responsible for paying the applicable premium for Medicare Part B. This Plan will not pay this premium. In addition to the preceding eligibility rule, you must have first been a participant in the Plumbers' Union Local 12 Welfare Fund and eligible for Class A coverage under one of the following categories:

1. <u>Members who retire on or after March 1, 2000</u>:

If you retired on or after March 1, 2000, you must satisfy each of the following to be eligible:

- You must have retired under the Plumbers' Union Local No. 12 Pension Plan at age 60 or later and have been credited with contributions to the Plumbers' Union Local No. 12 Welfare Fund of at least 12,000 hours over the 10 consecutive years immediately preceding such retirement. Contributions include employer contribution and self-payment, or COBRA contributions made to the Welfare Fund.

- You must have been enrolled in Class A coverage under the Welfare Fund continuously during the 10 years prior to your enrollment in this Retiree Medicare Supplemental Plan.

2. <u>Members who retire on or after September 1, 2013</u>:

Effective September 1, 2013 through August 31, 2023 you must satisfy the following to be eligible:
Effective September 1, 2013 through August 31, 2023, Class A coverage, less dental benefits, has been made available to Employees who retire under the Plumbers' Union, Local No. 12 Pension Fund on or after September 1, 2000, after attaining age 55 are eligible for coverage in the Fund. Participants who retire on or after September 1, 2003, also must have had 12,000 hours contributed to ***this Fund and the Pension Fund*** on their behalf in the 10 consecutive Plan Years immediately prior to retirement or 18,000 hours contributed to ***this Fund and the Pension Fund*** on their behalf in the 15 consecutive Plan Years immediately prior to retirement in order to be eligible. For the purposes of the foregoing provision, hours credited shall be actual hours contributed by a contributing Employer to the Fund on the Participant's behalf and 30 hours per week for each week that an Employee is disabled and 100 hours per month for each month the Participant has

made contributions to the Fund under the self-pay provisions of Paragraph I (A), (B)(4) of Section 1 and Section 14, below regarding "COBRA" – Continuation of Coverage.

For purposes of determining the self-pay hours that may be credited toward satisfying the 12,000-hour requirement stated in this 11 an eligible Participant will not be able to retroactively purchase such self-pay coverage when he/she retires. Only continued coverage, purchased under the Plan's self-pay provisions and purchased at a time permitted by the Plan to maintain continued eligibility, will be counted for the purpose of the 12,000 or 18,000-hour requirements.

3. Members who retire before March 1, 2000:

If you retired before March 1, 2000, you must satisfy each of the following to be eligible:

You must have retired under the Plumbers' Union Local No. 12 Pension Plan at age 60 or later and have been credited with contributions to the Plumbers' Union Local No. 12 Welfare Fund of at least 12,000 hours over the 10 consecutive years immediately preceding such retirement. Contributions include employer contributions and self-payment, or COBRA contributions made to the Welfare Fund.

If you retired at age 65 or later, you must enroll in the Retiree Medicare Supplemental Plan by August 1, 2000. If you retired after age 60 but before age 65, you must be enrolled in Class coverage under the Welfare Fund by August 1, 2000 and remain enrolled until age 65.

4. Members who retire with a disability pension on or after March 1, 2000:

If you retired with a disability pension on or after March 1, 2000, you must satisfy each of the following to be eligible:

You must have retired on a disability pension under the Plumbers' Union Local No. 12 Welfare Plan and have been credited with contributions to the Plumbers' Union Local No. 12 Welfare Fund of at least 12,000 hours over the 10 consecutive years immediately preceding such retirement. Contributions include employer contributions and self-payment, or COBRA contributions made to the Welfare Fund.

You must have been enrolled in Class A coverage under the Welfare Fund continuously during the 10 years prior to your enrollment in this Retiree Medicare Supplement Plan.

5. <u>Members who retire with a disability pension on or after September 1, 2013 through August 31, 2023</u>:

Effective September 1, 2013 through August 31, 2023, an eligible participant who has met the Plan's requirements for a disability pension under the Plumbers' Union Local No. 12 Pension Plan, and who has been credited with contributions to the Fund of at least 12,000 hours over the last 10 consecutive Plan Years or 18,000 hours over the last 15 consecutive Plan years immediately preceding such disability pension may be eligible to continue Class A coverage, less dental benefits. Coverage for the participant's spouse and eligible dependents is only available if the contributions COBRA enrollment or self-payments were based upon family coverage for the entire 12,000 or 18,000 hours. For the purposes of the foregoing provision, hours credited shall be actual hours worked for a contributing employer to the Fund, the crediting of 100 hours per month for each month the participant has made self-pay contributions to the Fund under COBRA or the self-pay provisions of I (A), (B)(4) of SECTION 1 and 14 of this Plan and participation through COBRA payments during said period (See COBRA – Continuation of Coverage).

An eligible Employee who is under the age of 55 and who retires on a disability pension may continue coverage by paying 50% of the full cost of coverage plus a 2% administrative fee for the first 29 months of coverage. On the 30th month of continued coverage the eligible Participant will be required to pay the full amount as set forth by the Trustees.

The Trustees reserve the right to amend, alter, or repeal these provisions and terminate such retiree coverage in their sole discretion at any time.

6. <u>Members who retire with a disability pension before March 1, 2000</u>:

If you retired with a disability pension before March 1, 2000, you must satisfy each of the following to be eligible:

You must have retired on a disability pension under the Plumbers' Union Local No. 12 Pension Plan and have been credited with contributions to the Plumbers' Union Local No. 12 Welfare Fund of at least 12,000 hours over the 10 consecutive years immediately preceding such retirement. Contributions include employer contributions and self-payment, or COBRA contributions made to the Welfare Fund.

If you retired at age 65 or later, you must enroll in the Retiree Medicare Supplemental Plan by August 1, 2000. If you retired before age 65, you must be enrolled in Class coverage by August 1, 2000 under the Welfare Fund and remain enrolled until age 65.

B. Eligibility Rules for Medicare Eligible Spouse

If the member is a retired eligible as described above and in the Welfare Plan Eligibility rules regarding retired participants, the spouse of the member who is also eligible for and enrolled in Medicare parts A and B may enroll in the Retiree Medicare Supplemental Plan.

C. Termination of Eligibility and Coverage

Eligibility and coverage will terminate for the covered person upon the earliest of the following:

- The date this Retiree Medicare Supplemental Plan or the Welfare Fund Plan terminates, whichever is earlier;
- The date the covered person dies. If the member dies, the surviving spouse's eligibility and coverage will nonetheless terminate if one of the terminating events occurs or, if earlier, on the date on which the surviving spouse remarries;
- The date on which the covered person is no longer enrolled in Medicare Parts A and B;
- The date on which a re-employed member becomes eligible again for Class A coverage under the Welfare Fund;
- The first day of the month for which the required premium is not timely paid; or
- The Trustees have the right to change, limit or discontinue Plan benefits at any time. If the Trustees abolish Supplemental Plan benefits, in whole or in part, the effective date of such amendment is the date on which a Participant's Supplemental Plan coverage terminates (if such benefits are abolished in whole) or are modified (if such benefits are only reduced).

D. ENROLLMENT

All eligible persons must enroll in this Supplemental Plan by completing forms that may be obtained from the Fund Administrator. Only those persons who satisfy the eligibility rules described above and in the Welfare Plan are eligible to enroll in the Supplemental Plan.

E. PREMIUM PAYMENT

In order to be eligible and to maintain eligibility, each person enrolled must pay a monthly premium to the Fund. The Board of Trustees determines the premium amount from time to time. When you enroll, you will be told what the current premium is and receive an update of any premium change. The monthly premium is due in advance of the month in which the coverage is provided and must arrive at the Fund office no later than the last day of the month preceding the month for which the premium is owed.

> **EXAMPLE:** Joe and his spouse Mary are age 65 and enrolled in Medicare parts A and B. They wish to enroll in the Retiree Medicare Supplemental Plan as of June 1, 2013.
> Their first monthly premiums are due at the Fund office no later than May 31, 2013 for June 2013 coverage, and for each month thereafter.

You should keep the Fund office informed of your current address at all times.

F. PLAN OF BENEFITS

The Plumbers' Union Local 12 Retiree Plan is a supplemental plan for Medicare Parts A and B. If Medicare has approved and paid the medical charge, the Retiree Plan will supplement Medicare's payment up to its limits. It provides coverage for that portion of your approved medical charge not paid by Medicare. The Plan also Provides a Medicare Part D. Prescription Benefit administered by Benistar. **Benistar** can answer questions on your prescription drug benefits at **800-236-4782**.

However, if Medicare denies payment and chooses not to cover the medical charge, this Plan will not supplement either. If Medicare has approved the charge, the Plan provides the following supplemental benefits:

a. Medicare Part A Hospital Inpatient

This is the portion of Medicare, which covers hospital inpatient charges. Each inpatient hospital stay is subject to a benefit period. This benefit period starts the day you enter the hospital or in special circumstances a Medicare Approved skilled nursing facility. The benefit period ends when you have been out of the hospital or Medicare Approved skilled nursing facility for 60 days in a row. Medicare Part A pays for all Medicare Approved covered services of your hospital stay for the first 60 days, except for a deductible. For inpatient days 61 through 90, Part A pays for all covered services except for a daily coinsurance. If you have been out of the hospital for at least 60 days in a row and then go back in, a new benefit period begins – your 90 days of coverage starts all over again and you are subject to another deductible. Medicare Part A allows you 60 reserve days should you be hospitalized over your 90-day benefit period. You have only 60 reserve days in your lifetime and you decide when you want to use them. For each reserve day you use, Medicare Part A pays all covered charges except for a daily coinsurance. **Coinsurance is that portion of your bill that you will be required to pay**. Medicare Part A will not pay any inpatient hospital charges beyond your 60-day reserve.

What the Local 12 Retiree Plan Pays

The Local 12 Retiree Plan pays your deductible for each Medicare Approved hospital stay. At present the Medicare inpatient deductible is $1,260.00. The Plan will cover your inpatient coinsurance amount for days 61 through 90. When you must begin using your 60-day reserve, The Retiree Plan will cover your daily coinsurance.

b. Medicare Part A Skilled Nursing Facility Care

Sometimes after an inpatient hospital stay, you will need inpatient rehabilitation or skilled nursing care.

If you meet certain conditions, **determined and Approved by Medicare**, Medicare will pay for all covered services for the first 20 days in an approved facility. For the next 80 days, you must pay a daily coinsurance amount. Medicare allows 100 days for this service. It does not cover any service considered custodial or any services incurred in a nursing home.

What the Local 12 Retiree Plan Pays

The Retiree Plan will pay your coinsurance for the 21st to 100th day in a Medicare Approved skilled nursing or rehabilitation facility.

c. Medicare Part A Home Health Care & Durable Medical Equipment

Medicare will pay the full-approved cost of Medicare Approved home health visits from a Medicare-participating home health agency. There is no limit to the number of covered visits you can have. Medicare covers 80% of approved durable medical equipment (e.g., wheelchairs and hospital beds).

What Local 12 Retiree Plan Pays

AThe Local 12 Retiree Plan will cover your 20% copay for all Medicare Approved durable medical equipment.

PLEASE CONTACT MEDICARE AT 1-800-633-4227 OR
VISIT Medicare.gov ADDITIONAL MEDICARE COVERAGE INFORMATION

d. Hospice Care

e. Medicare Part A

f. Hospice care is a support service provided to terminally ill patients. It can be provided at home or inpatient in a Medicare Approved facility. Medicare will pay for most of the cost of a hospice program provided these services are rendered by a Medicare-certified hospice and certain other conditions are met.

g. As a hospice patient, you are allowed hospice care for two 90-day periods followed by an unlimited number of 60-day periods. Your doctor must certify your need for this service prior to each period of care. Under Medicare Part A you may be required to pay minimal copayments for outpatient prescription drugs and inpatient respite care (short-term care given to a hospice patient by another caregiver, so that the usual caregiver can rest.)

h. What the Local 12 Retiree Plan Pays

i. Local 12's Retiree Plan will pay the copayments for the outpatient prescription drugs and respite care you may be required to pay.

1) **Medicare Part B** – This is the portion of Medicare which covers services **other than** inpatient hospital charges. Charges included but not limited to doctor's services, inpatient and outpatient medical and surgical services, physical, occupational and speech therapy, diagnostic tests and approved durable medical equipment are paid under Medicare Part B.

2) Part B benefits do not begin until a yearly deductible has been met. At present this deductible is $147.00. The following chart will help you learn what Medicare Part B pays for and what the Local 12 Retiree Plan will pay.

SCHEDULE OF BENEFITS

Services	Medicare Pays	Local 12 Retiree Plan Pays
Yearly Deductible	**0**	**Pays Deductible**
Doctor's Services Inpatient and Outpatient	**80% Approved amount**	**20%**
Lab Services (Blood tests, etc.)	**100% Approved amount**	**0**
Surgery	**80% Approved amount**	**20%**
Anesthesia	**80% Approved amount**	**20%**
X-rays and diagnostic tests	**80% Approved amount**	**20%**
Emergency Room / Outpatient hospital	**80% Approved amount**	**20%**
Ambulance Services	**80% (limited benefit)**	**20%**
Physical and Speech Therapy (outpatient)	**80% with a combined yearly dollar maximum**	**20% (up to yearly dollar maximum)**
Occupational Therapy (outpatient)	**80% with a yearly dollar maximum**	**20% (up to yearly dollar maximum)**
Mental Health Care	**50% for most outpatient mental health services**	**50% balance of Medicare approved outpatient mental health**

Please note: Copayment amounts are higher if your doctor **does not accept assignment**. Doctors and other providers who accept assignment accept the amount Medicare approves for a service or supply as payment in full.

Doctors who don't accept assignment can require you to pay the full amount of the bill at the time of service. Medicare will then reimburse you its share of the bill. **Always ask your doctors and medical suppliers whether they accept assignment of Medicare claims.**

Medicare Part A and B benefits may be amended from time to time by the federal government. The Plumbers' Union Local 12 Retiree Plan may also be amended by the Trustees to reflect any changes in the Medicare Part A and B benefits.

Prescription Drug Benefit

The Plumbers' Union Local 12 Retiree Plan has a Medicare Part D prescription drug program in place for its participants. The member pays either a $60.00 Non-Formulary co-payment, $40.00 co-payment for a name brand prescription drug or a $20.00 co-payment for a generic prescription drug. **Benistar** can answer questions on your prescription drug benefits at **800-236-4782**.

Mail Order Drug Plan:

Your physician may prescribe a drug, which you will be required to take over a long period of time. These are known as maintenance drugs and examples include blood pressure medication and heart medication. A covered member may order these drugs by mail and save money in copayments. Please call the telephone number to the prescription plan located on the back of your prescription plan card or call the Fund Office for more information.

How to File a Medical Claim:

Members must forward (or ask their provider to do it for them) the original Explanation of Medicare Benefits form to the Fund office along with a copy of the original bill. Only benefits with a date of service on or after March 1, 2000 or the date you first become covered under this Supplemental Plan will be considered for coverage.

EXCLUSIONS AND LIMITATIONS

In addition, or supplemental to any Plan Exclusions stated elsewhere in this Plan, the coverage, benefits and rights stated in this Supplemental Plan are subject to and limited by the following exclusions, and such plans do not cover following:

1. Any medical service not Approved and paid for by Medicare. Any charge denied by Medicare.

2. A treatment or charge for which any benefits are available through a governmental program (local, state, national or foreign) which provides or pays for health services. It does not include Medicaid or Medicare.

3. Any treatment or charge incurred while the Covered Person is incarcerated in a state or federal prison;

4. Any service performed outside the United States;

5. Charges that the Covered Person is not required to pay;

6. Any service, treatment or charge, which is not Medically Necessary for the treatment of an illness, injury or disease or treatment, which is not Medicare Approved;

7. Charges incurred as a result of Custodial Care;

8. Cosmetic surgery, procedures or treatment (e.g., the treatment of acne lesions, tattoos, plastic revisions (such as face lifting), rhinoplasty, and similar cosmetic procedures);

9. Injury as a result of war, declared or undeclared, including armed aggression;

10. Bodily injury or disease arising out of or in the course of employment;

11. Charges for which the Covered Person is entitled to benefits under any other group medical plan which is primary;

12. Charges incurred for services furnished by a legally licensed hospital that is limited to alcoholism or related alcoholic disorders when the plan member has been confined as the result of a court order stemming from a violation of a drunk driving statute;

13. Any drug, device, therapy, medical treatment or procedure that is considered experimental or investigational;

14. Exercise, aerobic, biofeedback or meditation programs;

15. Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated;

16. Charges for maintenance care. Unless specifically mentioned otherwise, the plan does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function;

17. Nursing home care;

18. Routine foot care;

19. Psychological testing or neuropsychological tests;

20. Surgery which is defined as being performed for the satisfaction of the individual and not Medically Necessary;

21. Any charges incurred as the result of committing or attempting to commit a felony or felonious act;

22. Any charge which exceeds the fair and reasonable value of such services and supplies as determined by the Trustees of the Plan, or which exceeds the charges Approved by Medicare;

23. Tests for, and the cost of, eyeglasses or hearing aids, including laser surgery, hearing aids.

24. Services beyond the scope of the license of the person performing them;

25. Intentionally self-inflicted injury;

26. Suicide or attempted suicide;

27. Any claims arising from the covered person's taking, inhaling or absorption of any gas, poison, non-prescribed drug or medicine other than as a result of an accident;

28. Any claims arising out of injuries incurred while the covered person was driving a motor vehicle while intoxicated (and the covered person will be deemed intoxicated if toxicology or other tests indicate alcohol in the blood in excess of the intoxication level of the State in which the accident occurred);

29. Any claims which otherwise would be covered, where the covered person has not complied with the subrogation procedures or notice requirements for the benefit; and

30. Dental care and dentures;

31. Nicorette gum and/or smoking cessation medications/programs;

32. Non-prescription drugs or medications, over the counter medical supplies;

33. Dietary supplements and meals, weight gain/loss medications, including muscle enhancement drugs and diet drugs;

34. Any expenses, charges or drugs incurred for the treatment of sexual dysfunction.

DEFINITIONS

Custodial Care shall mean any service or supply, including room and board, which (a) is furnished mainly to help a covered person meet his/her daily needs; and (b) can be furnished by someone who has no professional health care training or skills. Custodial Care also means custodial care as defined for purposes of Medicare.

Emergency Admission/Medical Emergency shall mean the immediate admission of a patient to a hospital for treatment of the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could endanger health and result in permanent disability. Examples include, but are not limited to, heart attack, stroke, and serious burns and poisoning. A Hospital admission or Surgery made or performed for the convenience of the Physician or patient is not a medical emergency.

Experimental or Investigational shall mean any drug, device, therapy or medical treatment or procedure if it falls within any of the following:

1. It is considered by any governmental agency or subdivision, including but limited to the Federal Drug Administration, the Office of Health Technology Assessment or the Health Care Financing Administration Coverage Issues Manual to be:

   a. experimental or investigational;
   b. not considered reasonable and necessary; or
   c. any similar finding;

2. It is not covered under Medicare reimbursement laws, regulations or Interpretations;

3. It is not commonly and customarily recognized by the medical profession as appropriate for the condition being treated;

4. It is furnished in connection with medical or other research;

5. Reliable Evidence indicates that the drug, device, therapy, medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or

6. Reliable Evidence indicates that the consensus of opinion among experts regarding the drug, device, therapy or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Hospice means an organization which provides palliative and supportive care for a terminally ill covered person under a hospice care program. Palliative and supportive care means care and support provided mainly for the purpose of lessening or controlling pain or symptoms; it makes no attempt to cure the covered person's terminal Illness.

Hospital shall mean only an institution, which meets each of the following requirements:

(a) holds a license as a hospital if a license is required in the domicile of the State;

(b) is operated primarily for the reception, care and treatment of sick, ailing or injured persons as inpatients;

(c) providers 24 hour-a-day nursing service by registered or graduate Nurses;

(d) has a staff of one or more licensed Physicians available at all times;

(e) provides organized facilities for diagnosis and major Surgical Procedures;

(f) is not primarily a clinic, nursing or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts or the mentally ill;

(g) is operated for compensation from its patients, provided however, if a unit or area of a hospital is primarily operated for care of convalescent or ambulatory patients or for rehabilitation purposes, confinement in such unit or area shall not be considered hospital confinement unless such confinement is for purposes other than convalescence and rehabilitation, and the covered person is not ambulatory during such confinement.

Illness of Sickness shall mean any bodily disorder or disease, which manifests treatable symptoms and requires treatment by a Physician. All such conditions existing concurrently or successively, which are due to the same or related causes, shall be considered as one sickness or Illness.

Injury shall mean all damage to a person's body due to an accident or accidental means and all complications arising from that damage.

Medicare means part A (hospital benefits) and Part B (physician's benefits) of the federal government's health care program for those individuals totally disabled prior to age 65 and those retired individuals age 65 and over, provided by Title XVII of the Social Security Act, as amended from time to time.

Medicare Approved means Medicare has agreed to pay the provider or facility charge. Non-Medicare Approved charges are not be paid by this Plan.

Medically Necessary shall mean that a Medicare Approved specific Surgical Procedure, medical care, treatment, service or supply incurred upon the advice and approval of a Physician is reasonably consistent, commonly and customarily recognized by Physicians as appropriate, essential and medically required for the treatment or management of a diagnosed medical condition, Illness or Injury. Medically Necessary does not include a procedure, care, treatment or service for educational purposes, which is experimental or cosmetic in nature or purpose. Medically Necessary shall not include a procedure, care, treatment or service, which is solely for the patient's convenience or that of the patient's family or the medical provider. To be Medically Necessary, a procedure, care, treatment or service must be furnished in the least intensive type of medical care setting or facility required by the patient's condition. The fact that the patient's Physician, or some other provider, has furnished, prescribed, ordered, recommended, or approved a service, treatment, Surgical Procedure or prescription does not of itself make the aforementioned service, treatment etc. Medically Necessary.
The determination of being Medically Necessary will be solely made by the Board of Trustees based on a review of the patient's medical records.

Physician shall mean a Doctor of Medicine (M.D.), a doctor of osteopathy (D.O.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.M.D.) a doctor of podiatric medicine (D.P.M.) and an optometrist (O.D.), as the context requires for the particular procedure and good medical practice.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, therapy or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, therapy or medical treatment or procedure.

CLAIM DENIAL AND APPEAL PROCEDURES

If a claimant's claim is denied in whole or in part, the Fund Office will notify the claimant in writing of such denial and the reason for the denial within 90 days after receipt of the claim by the Fund Office, unless special circumstances require an extension of time to process the claim, in which case the claimant will be notified of the reason for the extension, and the Fund Office will notify within an additional 90 day period. If the claimant fails to receive in writing a response within the above time period, the claimant may consider the claim deemed denied and appeal the decision to the Trustees, as described below.

A claimant whose claim has been wholly or partially denied may submit a written appeal to the Trustees within 60 days from the date of the claimant's receipt of such denial. Only written appeals will be considered. Such an appeal should be addressed to the Fund

Administrator and must include any written or documentary proof which supports the claim, or any other information the claimant wishes to submit for the Trustees' consideration, whether or not such proof had previously been submitted. The claimant may, but is not required to, request a hearing before the Trustees. The claimant has the right to appear and may be accompanied by his or her attorney.

The Trustees will generally review all appeals at their next regularly scheduled meeting unless the letter requesting the appeal is received by the Fund Office within thirty (30) days of such meeting. In such case, the Trustees will review the appeal no later than the second regularly scheduled meeting of the Trustees following the receipt of the request for review. If special circumstances exist, the Trustees may review the matter no later than the third regularly scheduled meeting following the receipt of the request for review. The claimant will be notified in such event. If the claimant has requested a hearing, the Trustees will schedule the hearing and notify the claimant of the time and place of the hearing. The claimant is required to submit all evidence or information upon which the claimant relies no later than the date of the hearing or, if no hearing is scheduled, prior to the Trustees' decision on the appeal.
No claimant, or any person acting in his or her behalf, may resort to a court of law or equity, or any other judicial, administrative or other agency, without first exhausting the remedies as set forth above and providing all information or evidence in support of such claim to the Trustees in the claimant's appeal. No claimant may raise any issues not raised before the Trustees or introduce any evidence or information; in a court proceeding that was not presented to the Trustees at the time in which they rendered their decision on appeal. The Trustees may request, and the claimant shall provide, such information as the Trustees may deem necessary to their full and fair review of the claim appeal.

ASSIGNMENT AND SUBROGATION RULES

Assignment Rules

If a covered person suffers an injury, illness or a loss in an accident or other event or occurrence as a result of an act or omission by another person, a claim may be made for damages or other recovery against the other person by the covered person. The Plan has the right to obtain the proceeds of any recoveries, settlements or judgments, no matter how characterized (e.g., as payments for medical bills, pain and suffering, loss of consortium of a spouse or child or other family member, loss of income or otherwise), by the covered person to the extent of the total benefits paid, or to be paid in the future, to or on behalf of the covered person.

A covered person who applies, or who intends to apply, for any benefits provided by the Plan by reason of an Injury is required to notify the Fund Office, as a condition for eligibility for benefits under the Plan. The covered person is required to notify the Fund Office within seven days of any accident or injuries for which the covered person will seek payment from the Fund Office. The covered person is required to immediately notify the Fund Office of any recoveries, settlements or judgments recovered against any source (e.g., the person at fault, any insurance company, etc.), and the Plan shall have a

lien and a first priority right of recovery from such recoveries, settlements or judgments. The Plan shall be reimbursed from such recoveries as stated herein. The covered person must complete such forms and supply such information as may be requested by the Fund Office.

The Fund Office will require that the covered person assign his or her rights to any recoveries, settlements or judgments, and that the Plan be paid from such recoveries, settlements or judgments as a first right of recovery (i.e., ahead of the covered person, his or her attorneys, and any other person, and without reduction for attorneys' fees or other costs or expenses). Such recoveries, settlements or judgments shall constitute Plan assets to the extent of the benefits paid or to be paid by the Plan, and any person who handles such assets shall hold them in trust for the Plan. The covered person shall be required to sign an assignment form in order to be eligible for benefits arising out of this Injury. However, the failure of any covered person to sign an assignment form shall in no way affect the Plan's right to enforce these provisions and to obtain the proceeds of any recoveries, settlements or judgments, no matter how characterized, as described above. Any covered person who has the Plan pay his or her claims does so with the understanding that these Assignment and Subrogation rules are binding upon the covered person, his or her attorneys, or the agents, assigns or heirs and executors of the covered person. The covered person is required to pay his or her own legal expenses and the covered person is required to notify his or her attorney of these provisions and assignment. Any amounts recovered by the covered person in excess of the full amount expended by the Fund may be retained by the covered person or used to pay other legal expenses.

Subrogation Rules

In the event a covered person suffers an Injury, Illness or loss as a result of a negligent or wrongful act or omission by a third party, the Plan has the right to pursue subrogation. The Trustees will be subrogated and may succeed to the covered person's right of recovery against the third party, as determined by the Trustees in their sole discretion. The covered person agrees to help the Trustees use this right when requested.

Enforcement Procedures and Remedies

In addition to any legal or equitable remedy that may be available under applicable law, the Trustees may exercise the following remedies if a covered person fails to comply with the Assignment and subrogation requirements.

- Refuse to pay any benefits related to the covered person's injuries or illness.
- Recover from the covered person benefits already paid through deducting any overpayments from claims otherwise payable. The Trustees may also offset claims payable to a covered person.

- Assess interest on the outstanding benefits or the number of claims paid at a rate of 12-percent per annum, until paid.

- In the event the Trustees institute litigation to enforce these provisions, the covered person, and any other responsible person, shall be required to pay the Plan's costs and attorneys' fees, as well as any investigation fees.

The Trustees may promulgate rules and regulations to govern procedures hereunder.

PLAN INFORMATION REQUIRED BY ERISA

The following information together with the information contained in this Summary Plan Description is being provided to you in accordance with government regulations.

Type of Administration of the Plan

Most of the benefits under this Plan, including your medical and prescription drug benefits, are currently administered by the Fund Office. The Plan has contracted with a prescription drug manager to administer the prescription drug benefits. These benefits are self-funded. Any appeal of the denial of these benefits is made to the Board of Trustees.

The Plan is administered and maintained by a joint Board of Trustees currently consisting of three Union Trustees and three Employer Trustees. The Board of Trustees is governed by the Agreement and Declaration of Trust established and maintained in accordance with the Collective Bargaining Agreements.

Name and Address of the Plan Administrator

The Trustees are considered to be the Plan Administrator. The Trustees have complete discretionary authority to determine eligibility for benefits under the Plan, except where expressly delegated, or to construe the terms of the Plan, including ambiguous or disputed terms of the Plan, the Agreement and Declaration of Trust or other Fund documents or policies.

The Plan is administered by and for the Trustees through the:

Plumbers' Union Local No. 12 Welfare Fund Retiree
Medicare Supplemental Plan
1230-1236 Massachusetts Avenue
Boston, Massachusetts 02125
Telephone Number (617) 288-5400
(800) 452-9995

Fax: (617) 288-3871

The Trustees may delegate their authority with respect to the denial, granting, and administration of claims to an insurance company or other appropriately named fiduciary and may enter into an agreement with such insurer for the handling and determination of claims including, but not limited to, the processing, investigation, granting or denial of claims and appeals therefrom. In the event the Trustees have so delegated their authority, such insurer shall be the named fiduciary for purposes of review of a Participant's or beneficiary's claim and claim appeal and have discretionary authority to review such claim and claim appeal.

Name and Address of the Fund Administrator

Roger Gill, Administrator
Plumbers' Union Local No. 12 Welfare Fund
Retiree Medicare Supplemental Plan
1230-1236 Massachusetts Avenue
Boston, MA 02125
Telephone Number (617) 288-5400
(800) 452-9995
Fax: (617) 288-3871

Type of Plan

The Plan supplements certain medical benefits and prescription drug benefits approved by Medicare and not fully covered by Medicare. Only care approved by Medicare and for which Medicare pays its portion may be eligible for supplemental coverage by the Plan.

Funding Medium

The assets and reserves of the Fund are held in trust by the Trustees in a trust fund pursuant to an Agreement and Declaration of Trust. Assets for the purpose of establishing reserves and to pay benefits and expenses are accumulated in the State Street Bank and Trust Company in the name of the Fund.

This Plan is funded through premiums paid by covered persons. The amount of premium is established by the Trustees from time to time, and the Trustees have reserved the right to change the premium at any time. Contributions are held in a Trust Fund for the

purpose of providing benefits to covered persons and defraying reasonable administrative expenses.

Names and Address of Members of the Board of Trustees

BOARD OF TRUSTEES

Employer Trustees	**Union Trustees**
Jeremy Ryan	James Vaughan
Kevin J. Walsh	Barry Keady
Joseph Cannistraro	Timothy G. Fandel
Joseph Valante Jr.	Roger B. Gill

Send correspondence to:

Board of Trustees
Plumbers' Union Local No. 12 Welfare Fund
Retiree Medicare Supplemental Plan
1230-1236 Massachusetts Avenue
Boston, MA 02125

Name and Address of Designee as Agent for Service of Legal Process

The Board of Trustees has designated Roger Gill, Fund Administrator, as the agent for service of legal process. Process may be served at 1230-1236 Massachusetts Avenue, Boston, MA 02125. Service of legal process may also be made upon the Plan Trustees at the same address.

Employer Identification Number/Plan Number

Employer Identification Number (EIN) as assigned by the Internal Revenue Service to the Board of Trustees as Plan sponsor is 04-2157164. The Plan Number is 501.

Fiscal Year of the Plan

All financial records of the Plan are kept on a fiscal year basis beginning on September 1 and ending on August 31.

Eligibility

The Plan's requirements with respect to eligibility, as well as the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits, are described in this Plan Description.

Description of Benefits

The benefits provided by the Plan are set forth in this Plan Description.

Termination Provisions

The Fund shall continue during the term of the collective Bargaining Agreements referred to herein and during the term of any renewal or extension of the Agreements as long as there are available assets. In the event that the obligations of all of the participating employers to make contributions and negotiations therefore terminate, the Trustees will determine how any assets which may remain after expenses have been paid will be disposed of. The distribution made by the Trustees shall be made only for the benefit of former eligible employees and for legitimate Fund purposes; for example, the purchase of insurance benefits, the provision of benefits in any form, or the transfer to another trust fund.

Claims and Appeal Procedure

The procedure to follow for filling a claim for benefits is set forth in this Plan Description. If all or any part of your claim is denied, you may appeal that decision. See the Plan's claim denial and appeal procedures.

Amendment to the Plan/Trustees' Right to Change or Discontinue the Plan

The Provisions of this Plan may be modified or amended by the Trustees in their sole discretion at any time. Without limiting the foregoing, the Trustees expressly reserve the right to add to, subtract from, modify or discontinue any benefits hereunder and to modify eligibility rules for all benefits under the Plan. Such amendments may be retroactive in the discretion of the Trustees. The Trustees also reserve the right to adopt and amend from time to time any rules, policies or regulations they may deem appropriate.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant eligible for coverage under the Plumbers' Union Local No. 12 Welfare Fund Retiree Medicare Supplemental Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants shall be entitled to:

- Examine, without change, at the Fund Office all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated copy of the Plan. A reasonable charge may be made for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan administrator and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Plumbers' Union Local No 12 Welfare Fund

1230-1236 Massachusetts Avenue, Boston, MA 02125
Telephone 617-288-5400, Fax 617-288-3871

DATE: August 28, 2020

TO: Participants of the Plumbers' Union Local No. 12 Welfare Fund

FROM: Board of Trustees and Administrator

SUBJECT: Plan Changes

To address the effect of the pandemic on our industry, as well as the ever-increasing health care and prescription drug costs, the Trustees have amended the Plumbers' Union Local No. 12 Welfare Plan (the "Plan"); these amendments are summarized, below, in this notice:

1. **Section 14. New COBRA Rates**. The monthly rates charged to new enrollees on COBRA on or after October 1, 2020 will increase as follows:

COBRA PLAN	COVERAGE	MONTHLY PREMIUM
Individual HMO	Medical and Prescription Drug only	$708
Family HMO	Medical and Prescription Drug only	$1,857
Individual HMO	Medical, Prescription Drug, Dental and Vision	$736
Family HMO	Medical, Prescription Drug, Dental and Vision	$1,954
Individual PPO	Medical and Prescription Drug only	$778
Family PPO	Medical and Prescription Drug only	$2,041
Individual PPO	Medical, Prescription Drug, Dental and Vision	$806
Family PPO	Medical, Prescription Drug, Dental and Vision	$2,137

If you were already covered by the Welfare Fund pursuant to COBRA prior to October 1, 2020, you monthly rates will remain the same.

2. **Section 6. Deductible Reimbursement**. As of September 1, 2020, the Trustees have made arrangements with Welfare Plan insurer Blue Cross Blue Shield of Massachusetts to reduce the Annual Deductible for an Individual Subscriber from $500 to $250 and from $1,000 to $500 for a Family Subscription. The Plan had previously reimbursed 50% of your annual deductible and with the reduction of deductible by 50% the Plan is eliminating Deductible Reimbursement for claims incurred on or after September 1, 2020.

altus dental™
Altus Dental Insurance Company, Inc.

Understanding Your Plan
Your Benefit Summary

PLUMBERS UNION LCL 12 WELFARE

Group Number: 6480-0001

Altus Dental Plus With Connection Dental

Effective: 09/01/2021 - 08/31/2022

This is a summary of benefits. The information shown here is not a guarantee of payment. Refer to the Certificate of Coverage for the full plan terms. The Certificate includes any limitations or exclusions not seen here. For a complete listing of frequencies and limitations go to **www.altusdental.com/content/exclusionsandlimitations**. To be covered, services must be dentally necessary and appropriate as per our review guidelines.

Please note: Exams, cleanings, bitewing x-rays, single x-rays, fluorides, sealants and full mouth/Panorex x-rays do not count against your annual maximum."Certain oral surgery procedures do not count towards the annual maximum."

Icons

(P) Pre-treatment Estimate Recommended
(A) Prior Authorization Required
(D) Deductible Applies

Provisions

Annual Maximum: $1,500
Elective Orthodontic Lifetime Maximum: $2,000
Maximum Lifetime Cap: Unlimited
Individual Deductible: $50
Family Deductible: $150
Dependent Coverage - Dependent children are covered under these benefits up until the end of the month that they turn 26.

Procedure	Covered At	Frequency / Limitations
DIAGNOSTIC		
Oral exam	100%	Twice per calendar year
Bitewing x-rays	100%	One set per calendar year
Complete x-ray series or panoramic film	100%	Once every 36 months. A panoramic film is a benefit for individuals ages 6 and older.
Single x-rays	100%	As required
PREVENTIVE		
Cleaning	100%	Twice per calendar year
Fluoride treatment	100%	For children under age 19 twice per calendar year
Sealants	100%	For children under age 16, once every 36 months on unrestored permanent molars
Space maintainers	100%	Once every 60 months for lost deciduous (baby) teeth
RESTORATIVE		
Amalgam (silver) fillings and composite (white) fillings	80% (D)	
(P) Crowns over natural teeth, build ups, posts and cores	50% (D)	Replacement limited to once every 60 months
Recementing crowns or bridges	80% (D)	Once every 60 months
ENDODONTICS		
Root canal therapy on permanent teeth	80% (D)	One procedure per tooth per lifetime.

Continued on back

Icons

P Pre-treatment Estimate Recommended

A Prior Authorization Required

D Deductible Applies

Beyond Benefits

When you visit us at altusdental.com, you can access a wealth of important dental health information and manage your plan by:

- Checking your benefits and claims
- Reviewing your deductibles and maximums
- Using our Find A Dentist tool to find a dentist in your area

Out-of-Network Coverage

You have the freedom to choose any dentist, but it is important to know that your out-of-pocket costs may be higher when you visit a dentist who does not participate with Altus Dental. Non-participating dentists have not agreed to accept the Altus Dental allowance as payment in full, so services from an out-of-network dentist may cost you more. You may also have to pay the dentist at the time of service and file a claim yourself. To find a participating dentist near you, use our Find a Dentist tool at www.altusdental.com.

Procedure	Covered At	Frequency / Limitations
PERIODONTICS		
P Root planing and scaling	80% D	Once per quadrant every 24 months
P Osseous (bone) surgery	80% D	Once per quadrant every 24 months (bone grafts are not covered)
P Gingivectomies	80% D	Once per site every 24 months
P Soft tissue grafts	80% D	Once per site every 60 months
P Crown lengthening	80% D	Once per site every 60 months
Periodontal maintenance following active therapy	100%	Once every 3 months; if alternating with routine cleanings, there should be 3 months between a cleaning and the next maintenance procedure
PROSTHODONTICS		
P Bridges and crowns over implants	50% D	Replacement limited to once every 60 months
P Partial and complete dentures	50% D	Replacement limited to once every 60 months
Repairs to existing partial or complete dentures	80% D	Once per calendar year
Rebasing or relining of partial or complete dentures	80% D	Once every 60 months
IMPLANT SERVICES		
P Surgical placement of endosteal implant and abutment	50% D	Replacement limited to once every 60 months
EXTRACTIONS AND ORAL SURGERY		
Extractions and other routine oral surgery	80% D	
ORTHODONTICS		
P Elective braces and related services	50%	For dependent children under the age of 19. Subject to a lifetime maximum. No pre-approval required.
OTHER SERVICES		
Palliative treatment (minor procedures necessary to relieve acute pain)	80% D	Twice per calendar year
General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures	80% D	

Note: ***This plan does not include a missing tooth clause. In addition, crowns, bridges, partials and complete dentures are paid when the permanent structure is inserted (seated) by the dentist.*** Member coverage must be active on the date that the permanent structure is inserted and payment is based on benefits available on that day — for example, if the member's annual maximum has been paid prior to the insertion of the permanent structure, the service will not be paid.

* Time limits on services (e.g. 6, 12, 24, 36, or 60 months) are figured to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

DavisVision™

davisvision.com | 1 (877) 923-2847, 8609

The Plumbers Union Local No. 12 Welfare Fund your vision plan

Client code: 8609

Frequency

Exam: Every other January 1
Lenses & lens upgrades: Every other January 1
Frame: Every other January 1
Contacts, evaluation & fitting: Every other January 1

Members under 19 and over 60 years of age are entitled to services annually.

Sign up during open enrollment

For more details about the plan, visit davisvision.com/member and enter your Client Code or call 1 (877) 923-2847 and enter your Client Code when prompted.

Exams & Services

Eye Exam copay:
$0

Contacts evaluation, fitting & follow-up:

Conventional lens	Specialty lens
$50 copay	**$50 copay** **$60 allowance** **plus 15% savings**[1]

Lenses

Lens copay:
$0

Frame

Allowance:

$150

+Additional 20% **off** any overage.[1]

or

The Exclusive Collection copay:

Fashion	Designer	Premier
Covered in full	**Covered in full**	**Covered in full**

Contacts[2] in lieu of glasses

Allowance:

$150

+Additional 15% **off** any overage.[1]

or

The Exclusive Collection of Contact Lenses:[3]

Covered in full

Using your client code

Log in using your client code (listed above) at davisvision.com/member to find a list of in-network providers near you and access your benefit information.

The Exclusive Collection

The Exclusive Collection of frames is available at nearly 9,000 locations across the U.S. Log in to browse frames, and find a Collection near you.

Free breakage warranty

Your glasses are covered with our FREE one-year breakage warranty. Some limitations apply.

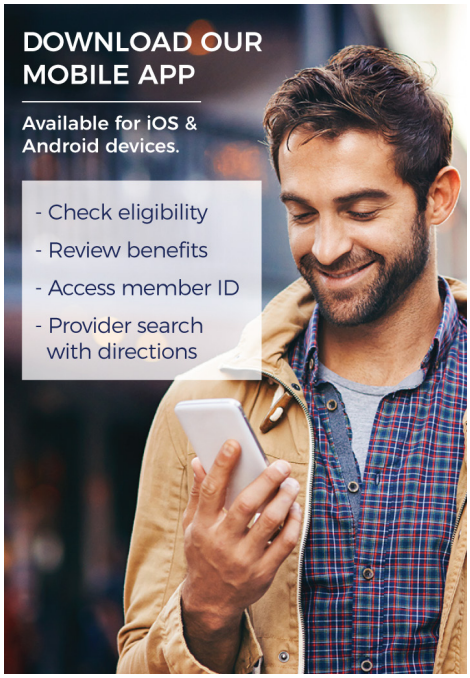
Find a network provider...

Enter your client code in the “Member Sign In” section of our website at davisvision.com/member to locate a provider near you including Visionworks.

Options & upgrades

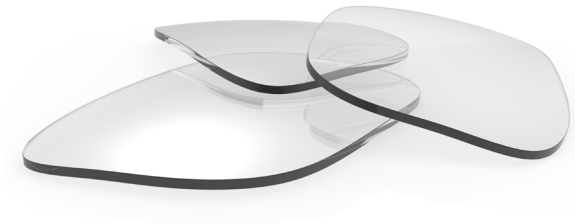
Lens options

Clear plastic single-vision, bifocal, trifocal or lenticular lenses (any RX)	$0
Polycarbonate Lenses (Children / Adults)	$0
High-Index Lenses 1.67	$0
High-Index Lenses 1.74	$120
Polarized Lenses	$0
Progressive Lenses (Standard / Premium / Ultra / Ultimate)	$0 / $0 / $0 / $175
Anti-Reflective (AR) Coating (Standard / Premium / Ultra / Ultimate)	$0 / $0 / $0 / $85
Ultraviolet Coating	$0
Tinting of Plastic Lenses (Solid / Gradient)	$0
Plastic Photochromic Lenses (Transitions® Signature™)	$0
Scratch-Resistant Coating	$0
Premium Scratch-Resistant Coating	$30
Scratch-Protection Plan (Single-Vision | Multifocal)	$20 | $40
Trivex Lenses	$50
Blue Light Filtering	$15



Additional savings

Retinal imaging (Member charge)	$39
Additional pairs of eyeglasses	30% discount[1]



Out-of-network benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network.

Out-of-network reimbursement schedule (up to)	
Eye Examination: $30	Trifocal Lenses: $60
Frame: $50	Lenticular Lenses: $70
Single-Vision Lenses: $40	Elective Contact Lenses: $100
Bifocal / Progressive Lenses: $50	Visually Required Contacts: $100

1. Some limitations apply to additional discounts; discounts not applicable at all in-network providers. 2. Contact lens coverage varies by product selection. Visually Required contacts are covered in full with prior approval. 3. The Davis Vision Exclusive Collection of Contact Lenses is available at participating providers. Evaluation, fitting and follow-up care for Collection contacts are covered in full. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.